IN THE SUPREME COURT OF THE STATE OF NEVADA

ESTATE OF REBECCA POWELL, through BRIAN POWELL, as Special Administrator; DARCI CREECY, individually and as Heir; TARYN CREECY, individually and as an Heir; ISAIAH KHOSROF, individually and as an Heir; LLOYD CREECY, individually;,

Plaintiffs,

vs.

VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; and ROES A-Z;,

Defendants.

Supreme Court No.:

District Court No.: A-19-788787-C

RESPONDENTS' APPENDIX VOLUME IV

S. BRENT VOGEL
Nevada Bar No. 6858
ADAM GARTH
Nevada Bar No. 15045
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E	Defendant Valley Health System, LLC dba Centennial Hills Hospital Medical Center's Motion for Attorneys' Fees Pursuant to N.R.C.P. 68, N.R.S. §§ 17.117, 7.085, 18.010(2), and EDCR 7.60	2/2/2022	**423-485**

This 24th day of February, 2023

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Adam Garth

S. Brent Vogel
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Adam Garth
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Attorneys for Respondent Valley Health System, LLC dba Centennial Hills Hospital Medical Center

CERTIFICATE OF SERVICE

I hereby certify that on this 24th day of February, 2023, a true and correct copy of **RESPONDENTS' APPENDIX VOLUME IV** was served by electronically filing with the Clerk of the Court using the Odyssey E-File & Serve system and serving all parties with an email-address on record, who have agreed to receive electronic service in this action.

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By */s/ Heidi Brown*
An Employee of
LEWIS BRISBOIS BISGAARD & SMITH LLP

dyspnea, possibly due to rapid steroid taper. It was recommended to resume q8 steroids, low dose theophylline, and CTA of chest. On exam, patient was noted to have moderate coarse with mid-to-late expiratory wheezes with a regular cardiac exam. Oxygen saturation was 97% on 3 liters of oxygen. No recommendations for a higher level of care were given.

Patient asked for Ativan and was given 0.5mg at 223am on May 11. She had a prior order of Ativan 0.5mg IV push q8 as needed on file, which was last given at 1601 on May 10. She was transported to CT at 230AM, but it could not be completed due to patient's reported shortness of breath and anxiety. Per report, Dr. Concio gave an additional one-time order of .25mg of Ativan which was given at 327AM, which appeared to be somewhat effective. Patient eventually calmed down and her breathing appeared to be less labored at approximately 415AM, per nursing report. At 610AM, she was found sitting in her bed, unresponsive, with the oxygen mask at her feet. The patient underwent a CODE BLUE and was intubated by Dr. Blumberg who was able to suction a thick mucus plug. She was noted to be in asystole and thereafter PEA and eventually expired at 6:57 AM.

Review of the Coroner's investigation confirmed the pathological diagnoses of acute on chronic pneumonia with foreign body giant cells, pulmonary edema and hyaline membrane formation consistent with aspiration pneumonia, with Cymbalta over-medication as a contributing factor. Manner of death was considered suicide.

Rebecca Powell presented to Centennial Hills Hospital Medical center with acute respiratory failure and was critically ill on May 3, 2017. Patient was successfully extubated and was eventually transferred out of the ICU. On May 10, she was noted to have labored breathing at 411PM and a chest Xray and ABG was ordered. She was thereafter seen by Dr. Breeden, the pulmonary specialist, late that evening with a signature time stamp of 2209. Per RT documentation, her oxygen saturation was 92% on 3 liters at 1022PM.

Patient imaging done on May 9, was notable for bilateral diffuse interstitial opacities and on May 10, was repeated and noted to be without change.

Documentation of her oxygen saturation revealed that on May 6, she was requiring up to 70% oxygen with improvement over the following days and again a worsening in oxygenation reported by RT, requiring 15 liters oxygen on May 11 at 447AM.

Based on the above noted review of the Centennial Hills Hospital Medical Center records and the Coroner's investigation, it is evident that Ms. Powell had a significant aspiration event upon arrival to the medical center and was critically ill. This was a direct result of the Cymbalta overdose and what was perceived to be her attempted suicide. She was followed by Infectious Disease, Pulmonary, and the hospitalist team. Although she was noted to have some improvement during her hospital course, she was again noted to have respiratory difficulties on May 10, 2017. She was attended to throughout the night, by nursing, respiratory therapy, a rapid response team, and was seen that evening by Dr. Breeden. She was receiving broad spectrum antibiotics, including Zyvox and Cefepime, as well as Solumedrol IV and Heparin SQ. Based on the record review, she received 0.5mg of Ativan IV at 223am and .25mg at 337AM on May 11 with prior dose of 0.5mg given at 1601 on May 10. No other sedatives or any other medications that would impact sedation were given.

Upon review of the lung pathology, Ms. Powell developed diffuse alveolar damage which is manifested by injury to the alveolar lining and endothelial cell, pulmonary edema, hyaline membrane formation in the acute phase, much of which was found by the Coroner. Features include acute and progressive hypoxia with bilateral pulmonary edema due to alveolar injury, which was seen with Ms. Powell. This severe damage is the most common morphological pattern of adult respiratory distress syndrome (ARDS). Diffuse alveolar damage pattern is often characterized by hyaline membrane disease in the acute phase, which was confirmed by the Coroner.

Based on the above findings, to a reasonable degree of medical probability it is more likely than not that Ms. Powell's death was a consequence of her massive aspiration event from the time of admission, that progressed acutely to diffuse alveolar damage and ARDS, carrying with it a significant mortality. It is also very likely that Ms. Powell had a combined aspiration of acid and gastric contents, which also likely presented with a reversible non-infectious chemical pneumonitis and progressed to diffuse alveolar damage and ARDS.

It is highly unlikely that the total Ativan dose given would have led to any significant respiratory depression, with a sum of .75mg given the morning before her death. Doses much higher are often needed to cause a significant respiratory

deterioration and reduction in mental status. This was clearly not evident with Ms. Powell as she was observed to be awake and comfortable at 447AM on May 11. Had the amount of Ativan been of any significance, it would be expected that she would have been obtunded or at the very least difficult to arouse at 447AM. Contrary to the statement of Plaintiffs' expert, Dr. Hashim, Ms. Powell did not receive any other medications that would lead to sedation and was no longer receiving Midazolam. Acetylcysteine was given in an inhaled form and does not lead to excess sedation. In fact, only Metoclopramide may cause sedation but was written PRN and had not been given for greater than 36 hours prior to her death.

The multiple physicians documented diagnoses of Aspiration Pneumonia, Respiratory Failure, MRSA, suicide attempt, and leukocytosis. All of these diagnoses were very appropriate and correct for Ms. Powell.

Based on the pathology findings, and to a reasonable degree of medical probability, Ms. Powell progressed to diffuse alveolar damage and ARDS and would likely not have survived regardless of any care she received at Centennial Hills Hospital. Appropriate interventions were called in the evening prior to her death, on May 10, and were reported timely. Likewise, she underwent a rapid response and was appropriately attended to and evaluated that evening. She was well covered with IV antibiotics and steroids and was given adequate DVT prophylaxis. Finally, she was seen by Drs. Skankey and Shah and Dr. Breeden, the Pulmonologist assigned, who was fully able to assess her change in condition as he signed off on her note at 2209 on May 10. Ms. Powell was monitored adequately throughout her stay and did not require transfer to the ICU on May 10. Had she been moved to the ICU earlier the morning of May 11, to a reasonable degree of medical probability, her outcome would not have been different based on the coroner's report and diffuse changes noted on lung pathology. Moreover, the Ativan dosing did not in any way contribute to her death as she was noted to be alert over one hour after the final .25mg of Ativan dose was given, which is considered a negligible dose, and the combined total of any remaining, nonmetabolized Ativan in her system at the time of her death would not have suppressed her breathing as plaintiffs have alleged.

In conclusion, I disagree with Dr. Hashim's statement that the Ativan given was in any way contributory to Ms. Powell's death, that a repeat chest Xray would in any

way be of any assistance, as a recent one was done only several hours prior, and that she had been given other drugs which would have led to additional sedation.

I, likewise, disagree with him that Ms. Powell was misdiagnosed with Anxiety. Ms. Powell was clearly diagnosed with respiratory failure and aspiration pneumonia. It is not unusual that a physician may call in small doses of Ativan to help cope with breathing difficulty, which in no way labels the patient as having anxiety but simply helps with her symptoms.

Furthermore, from my review of the entire Centennial Hills Hospital chart for Ms. Powell, there is no problem whatsoever with the hospital documentation. The communication between the hospital staff and the physicians was perfectly acceptable and well within the standard of care. Staff made calls to Dr. Shah between 2:00 a.m. and 2:30 a.m. to report on Mrs. Powell's condition, which was entirely appropriate. Moreover, the nurses followed the instructions of the physicians timely and appropriately. The standard of care requires only that hospital staff notify the physician of the patient's condition and vital signs, which was done here.

To a reasonable degree of medical probability, Rebecca Powell died as described by the Coroner from an aspiration pneumonia that led to acute and diffuse alveolar damage, ARDS, and death. The Ativan dosing was in no way contributory to the event as the airways were clear of any debris, foreign body, or secretions.

Based on my education and practice, the physicians and staff acted within the standard of care and all actions or lack of actions did not in any way contribute to her death. Allegations by plaintiffs of more frequent monitoring by Centennial Hills Hospital, staff and independent physicians is unsupported. Ms. Powell's death stemmed from an acute event which more frequent monitoring or care could not have prevented. Statements made by nursing staff at Centennial Hills Hospital to Department of Heath and Human Services personnel do not accurately reflect the standard of care applicable to the care and treatment provided to Ms. Powell and those similarly diagnosed. Her death did not result from any departures from the standard of care by Centennial Hills Hospital or its personnel, nor did any such individuals breach the standard of care as it was applied to Ms. Powell's care and treatment. Her death, while tragic, resulted from the affirmative actions Ms. Powell took pertaining to her drug overdose and suicide attempt, and the

conditions which developed directly therefrom. Moreover, her death was an imminent event which was not predictable. Additionally, Nurse Pawlak's opinion that Ms. Powell could have been dead for up to an hour is medically unsupported. Ms. Powell was in PEA at the time the Code Blue was called. Had she been dead for an hour, there is no way her heart could have been restarted as it had during the Code. No further interventions by Centennial Hills Hospital or its personnel could have prevented this outcome.

Dated: May 19, 2021

Abraham Ishaaya, M.D.

Exhibit I

Exhibit I

CURRICULUM VITAE

Richard Lewis Ruffalo, M.D., Pharm.D., M.A., F.A.C.C.P.
Diplomat, American Board of Anesthesiology
Fellow, American College of Clinical Pharmacology
Assistant Clinical Professor Anesthesiology, UCLA School of Medicine
Past Chairman, Department of Anesthesiology, Hoag Memorial Hospital, Past Chairman, Pharmacy & Therapeutics Committee 1996-2008 and current Vice Chairman

Date of Birth:	October 9, 1949
Place of Birth:	Glendale, California
Mailing Address:	11 Sea Shell Newport Coast, California 92657
Telephone Numbers:	(949) 400-7310 (cell) (949) 640-0624 (home)
Fax Number:	(949) 675-0525
Email:	richard@ruffaloassociates.com

EDUCATIONAL BACKGROUND:

Under Graduate

University of California at Los Angeles (UCLA)	1967 - 1971 (BA - Zoology)

1. Post Graduate

University of California at Los Angeles (UCLA)	1971 - 1972 (MA - Molecular Biology)
University of Southern California, School of Pharmaceutical Sciences	1973 - 1977 (Pharm.D. - Doctor of Pharmacy)
University of Southern California/ Los Angeles County/USC Medical Center	1977 - 1978 (Post-Doctoral Residency - Clinical Pharmacology and Clinical Pharmacy)

Medical School

George Washington University School of Medicine and Health Sciences-Washington, D.C.	1983 - 1987 (M.D. - Doctor of Medicine with Distinction)

Post M.D. Residency Training

Washington Hospital Center/George Washington University School of Medicine, Washington, D.C.	1987 - 1988 (Internal Medicine Internship)
Post M.D. Residency Training University of California at Los Angeles (UCLA) School of Medicine-Department of Anesthesiology	1988 - 1991 (Anesthesiology Residency)
Board Certification: American Board of Anesthesiology	1992
Board Recertification: American Board of Anesthesiology	2009
Advanced Cardiac Life Support Recertification – continuously through	2015

Institution/Faculty Appointments

Assistant Clinical Professor of Anesthesiology, David Geffen School of Medicine, University of California, Los Angeles	1991 - Present
Chairman, Department of Anesthesiology, Hoag Memorial Hospital, Newport Beach, CA	1994 - 1996
Chairman, Pharmacy and Therapeutics Committee Hoag Memorial Hospital, Newport Beach, CA	1996 - 2008
Vice-Chairman, Pharmacy and Therapeutics Committee, Hoag Memorial Hospital, Newport Beach, CA	2008 - Present
Member, Medical Executive Committee Hoag Memorial Hospital, Newport Beach, CA	1994 - 1996
Member of the Medical Staff, Hoag Memorial Hospitals Health Care Systems	1991 - Present
Clinical Instructor/Lecturer, George Washington University, School of Medicine, Washington D.C.	1984 - 1988
Assistant Professor of Family Medicine, Loma Linda University School of Medicine, Loma Linda, CA	1980 - 1984

Visiting Professor in Clinical Pharmacology,
Al Hada Hospital, Taif, Kingdom of Saudi Arabia 1982

Instructor-Advanced Cardiac Life Support (ACLS) 1980 - 1984

Assistant Clinical Professor of Clinical Pharmacy and
Clinical Pharmacology
USC School of Pharmaceutical Sciences 1988 - 1990

Research Associate
USC School of Pharmaceutical Sciences 1980 - 1983

Assistant Clinical Professor of Clinical Pharmacy and
Clinical Pharmacology
USC School of Pharmaceutical Sciences 1978 - 1980

Clinical Instructor
USC School of Pharmaceutical Sciences 1977 - 1978

Graduate Teaching Assistant, Department of
Molecular Biology (UCLA) 1971 - 1972

Faculty-Research

Co-Investigator Department of Cardiology
George Washington University School of Medicine 1986 - 1988

Co-Investigator Department of Infectious Diseases
George Washington University School of Medicine 1984 - 1986

Co-Investigator-NIH/NCHSR Research Grant #1-R-18-0398-01
Drug Prescribing and Evaluation by Clinical Pharmacists
in the Long Term Care Patient". USC School of Pharmaceutical Sciences 1980 - 1984

Research Associate, Hyland Laboratories, Division of
Travenol Laboratories, Inc., Los Angeles, CA 1972 - 1976

NIH Research Fellow in Molecular Biology
Department of Molecular Biology/Parasitology,
University of California at Los Angeles (UCLA) 1971 - 1972

HONORS. AWARDS AND FELLOWSHIPS

Medical - Post Graduate

Diplomat, American Board of Anesthesiology. 1992
American Board of Anesthesiology Board Recertified 2009

Medical - Post Graduate

Fellow, American College of Clinical Pharmacology	1987 - present
ALPHA OMEGA ALPHA, National Medical Honor Society awarded at George Washington University School of Medicine	1986 - present
Doctor of Medicine (M.D.) with Distinction (Suma Cum Laude) George Washington University School of Medicine	1987
Merck Manual Award for Academic Excellence George Washington University School of Medicine	1987
1st Place-Edward A. O'Rorke Manuscript Competition in Clinical Pharmacology Sponsored by Cardiovascular Reviews & Reports	1985
National Pharmacology Essay Award-1st Place The Boehringer Ingelheim Centennial Award	1985
Lederle Pharmaceuticals Research Award for Young Investigators	1984

Graduate

NJH/NCHSR Research Grant #1-R-18-0398-01 to study physicians and clinical pharmacists prescribing for the long term care patient	1980 - 1984
RHO CHI National Honor Society Fraternity in Pharmacy	1977
NIH Research Fellowship in Molecular Biology UCLA Department of Molecular Biology	1971 - 1972
UCLA Department of Parasitology & Molecular Biology Research Fellowship	1971 - 1972

Undergraduate

UCLA College of Letters and Sciences Dean's Honor List	1969 - 1971
UCLA Department of Zoology Senior Honor's Research Traineeship	1970 - 1971

MEMBERSHIPS AND PROFESSIONAL AFFILIATIONS

1. Diplomate, American Board of Anesthesiology, 1992, Board Recertified 2009
2. ALPHA OMEGA ALPHA, Medical Honor Society
3. Fellow: American College of Clinical Pharmacology
4. American Society of Anesthesiologists
5. California Society of Anesthesiologists
6. American Medical Association
7. California Medical Association
8. Society of Teachers of Family Medicine
9. American College of Clinical Pharmacy
10. Expert Reviewer, Medical Board of California

PUBLICATIONS

1. Ruffalo RL, Master's Thesis: Design and Isolation of Kinetoplast RNA from Trypanosomes. UCLA, Dec 1972.

2. Ruffalo R, Namikas E, Thompson J, Pharmacotherapy Evaluation Service: An Innovative Approach to Better and More Cost Effective Care for Patients in the Long Term Care Facilitv. California Pharmacist, June 1978, Editorial.

3. Ruffalo R, Kalb I, Timolol A review of its Pharmacology and Therapeutics in Glaucoma, Drug Information Bulletin, 1979:3 :(3) pp 2-4. Brotman Memorial Medical Center, Culver City, California.

4. Price A, Ruffalo RL, Glaucoma: An Update, California Pharmacist, 1980: 28 pp 40-52.

5. Ruffalo RL, Thompson JF, Effect of Cimetidine on the Clearance of Benzodiazepines. NEJM 1980:303 pp753-54.

6. Ruffalo RL, Thompson JE, Segal J, Cimetidine-Benzodiazepine Drug Interaction. AJHP 1981:28 pp 1365-66.

7 Ruffalo RL, Thompson JF, Segal J, Diazepam-Cimetidine Drug Interaction: A Clinically Significant Effect. So Med J 1981:74 pp 1075-78.

8. Ruffalo RL, Thompson JF, Effect of Cimetidine on the Clearance of Flurazepam and Temazepam. AJHP 1982: 39 pp 236-42.

9. Ruffalo RL, Thompson JF, More on Cimetidine-Benzodiazepine Drug Interactions. So Med J 1982:75 pp382.

10. Ruffalo RL, Thompson JF, Use of Cimetidine and Acetylcysteine as Combined Antidotal Therapy in the Treatment of Acetaminophen Overdose. So Med J 1982:75(8) pp 954-58.

11. Ruffalo RL, Brummel-Smith K, Evaluation of Family Practice Residents' Skills in Clinical Pharmacology and Rational Therapeutics: A Novel Method of Dealing With an Old Problem. Abstract. Proceedings from 15th Annual Spring Conference, Chicago, Illinois. The Society of Teachers of Family Medicine. May 1982.

12. Thompson JF, Ruffalo RL, Nursing Home Care Improved by Physician/Pharmacist Teamwork. Am Pharm 1983:NS 23 pp 16-17.

13. Ruffalo RL, Thompson JF. Cimetidine and Acetylcysteine as an Antidote for Acetaminophen Overdose. In: Wagner D. (ed.) Year Book of Emergency Medicine1984.

14. Ruffalo RL, Garabedian-Ruffalo SM. Penicillin G for Anaerobic Lung Abscess. Ann Int Med 1983: 99(1) pp 125-6.

15. Thompson JF, Mc Ghan WF, Ruffalo RL, et al. Clinical Pharmacists Prescribing Drug Therapy in a Geriatric Setting: Outcome of a Trial. J Am Ger Soc 1984: 32(2) pp 154-9.

16. Garabedian-Ruffalo SM, Gray DL, Sax M, Ruffalo RL. A Retrospective Evaluation of a Clinical Pharmacist Managed Anticoagulation Clinic: Effect on Prothrombin Time Monitoring and Hospitalizations. AJHP 1985:42(2) pp 304-8.

17. Garabedian-Ruffalo SM, Ruffalo RL. Adverse Effects Secondary to Baclofen Withdrawal. Drug Intel & Clin Pharm 1985:19(4*)* pp 304-6.

18. Ruffalo RL, Garabedian-Ruffalo SM, Pawlson LG, Patient Compliance: The Major Impedance to Successful Medical Therapy. Am Fam Phys 1985:31(6) pp 93-l00.

19. Garabedian-Ruffalo SM, Ruffalo RL, Morrison P, Polis M. Augmentin. Drug Information Bulletin. George Washington University Medical Center. 1985: 10(1) pp 1-4.

20. Garabedian-Ruffalo SM, Ruffalo RL. Drug and Nutrient Interactions. Am Fam Phys. 1986: 33(2)165-76.

21. Ruffalo RL, Garabedian-Ruffalo SM, Garrett BL. A Rational Therapeutic Approach to the Treatment of Essential Hypertension. Part I. Cardiovascular Reviews & Reports. 1986; 7(8): 692-700.

22. Ruffalo RL, Garabedian-Ruffalo SM, Garrett BL. A Rational Therapeutic Approach to the Treatment of Essential Hypertension. Part II. Cardiovascular Reviews & Reports. 1986; 7(9): 818-823.

23. Garabedian-Ruffalo SM, Ruffalo RL. Alterations in Drug Effects Secondary to Vitamin Supplementation. Therapaeia. 1987,28 (1 4):3 8-42.

24. Garabedian-Ruffalo SM, Ruffalo RL. Nutritional Influence on Drug Therapies. Am J Cont Ed Nurse 1987,2(l-3):28-36.

25. Garabedian-Ruffalo SM, Ruffalo RL. A Review of the Compatibilities and Stabilities of Intravenous Preparation. Crit Care Nurs 1989; 9(2): 81-5.

26. Garabedian-Ruffalo SM, Ruffalo RL. A Rational Therapeutic Approach to the Treatment of Essential Hypertension. J Pharm Tech 1987; 3(5): 182-187.

27. Levy WS, Katz RJ, Ruffalo RL et al. Methionine Potentiates The Vasodilatory Effects of Nitroglycerin. Am Col Cardiol (Abstract)37th Annual Scientific Session 1988.

28. Garabedian-Ruffalo SM, Ruffalo RL. Drug-Induced Jaundice: An Uncommon But Puzzling Reaction. Postgrad Med 1988;84(5): 205-16.

29 Ruffalo RL, Aspiration Pneumonitis: Risk Factors and Management of the Critically Ill Patient. DICP, The Annals of Pharmacotherapy, 1990; November; 24: S12-S16.

30. Ruffalo RL, Jackson RL, Ofman JJ. The impact of NSAID selection on gastrointestinal injury and risk for cardiovascular events: Identifying and treating patients at risk. P & T 2002; 27(11):570-577.

PRESENTATIONS

Numerous lecture presentations made to audiences consisting of Physicians, Pharmacists, Nurses and other administrative and Allied Health Professionals in the following medical and Pharmacologic Areas:

Geriatrics

Treatment and Management of Glaucoma
Geriatric Pharmacology and Therapeutics
Use of Psychotherapeutic Agents in the Elderly
Drug-Induced Mental Status Changes in the Elderly
Post-Operative Delirium in the Elderly
Multimodal pain management in the Elderly
Multimodal analgesia in the Elderly
Multimodal antiemetic therapy in the Elderly
Sedative Hypnotics and Conscious Sedation in the Elderly

Pharmacokinetics

Clinical Pharmacokinetics for the Physician
Clinical Pharmacokinetics for the Pharmacists
Pharmacokinetic and Pharmacodynamic considerations and Drug-Drug interactions and the Cytochrome P450 Enzyme System

Intensive Care Medicine

Drug Use in the Intensive Care Patient
ICU Psychosis and Delirium and drugs
Aspiration Pneumonitis-Prevention and Management
Emergency Airway Management

Cardiology

Pharmacologic Management of Hypertension
Pharmacologic Management of Arrhythmias
Perioperative diagnosis and of Hypertension “White Coat Syndrome”
Anxiety and Pain induced cardiovascular complications

Infectious Disease

Antibiotic Prophylaxis in the Neutropenic Patient
Treatment of Periorbital & Orbital Cellulitis
Treatment of Aspiration Pneumonia
Treatment of Atypical Pneumonia
Treatment of Pelvic Inflammatory Disease
Drug induced Skin and Mucus membrane diseases (SJS/TENS, Linear IgA Bullous Dermatitis, Vasculitis, etc.)

Oncology

Pharmacology & Therapeutics in the Cancer Patient
Drug-Induced Neutropenia in the Oncology Patient

Clinical Pharmacology

Multi-Modal analgesia and anesthesia
Anti-Emetic multimodal drug management
Clinical Pharmacology of Drug and Food Interactions
Clinical Pharmacology of Drug Herbal interaction and toxicology
Adverse Drug Reactions & Interactions
H2 Antagonists and Benzodiazepine Interactions
Identification and Management of Adverse Drug Reactions
Drug-Drug Interactions and Pharmacogenomics of the Cytochrome P450 Enzyme System

Pulmonary

Treatment of Asthma and Status Asthmaticus and COPD
Emergency management of the Difficult Airway in the Emergency
Department and the ICU settings

Neurology

Assessment and Treatment of Parkinson's Disease
Perioperative management of Epilepsy and acute onset Seizures
Anticonvulants and SJS/TENS and Acute Hepatitis

OB/GYN

Thromboembolic Disorders Secondary to Estrogens
Treatment of Primary Dysmenorrhea
Diagnosis and treatment of Amniotic Fluid Embolism
Anti-Emetic treatment in Laboring Patients
Post C-Section treatment of Nausea

Emergency Medicine/Toxicology

Treatment of Drug(s) Overdose
Treatment of Acetaminophen Overdose
Treatment of Tricyclic Antidepressant Overdose
Treatment of Calcium Channel Blocker Overdose
Diagnosis and treatment of SSRI induce Serotonin
Syndrome

Anesthesiology

Management of the Difficult Airway
Multi Modal treatment of Peri-Operative Pain
Multi Modal treatment of Post-Operative Pain
Multi Modal Anti-Emetic Prophylaxis
Conscious Sedation management and Monitoring

Exhibit J

Exhibit J

Fee Schedule for Richard L. Ruffalo, M.D., Pharm.D., M.A.

My Fee Schedule is as follows:

$600.00/hour for record and deposition review, meetings, medical and/or pharmacology literature search and/or review, phone conferences, travel time, writing and review of motions, reports, opinions, etc.

$1,000.00/hour with a two hour minimum and four day cancellation notice, to take my expert deposition testimony locally in the Newport Beach, Ca. area. Travel time to anywhere else is at $600.00/hour, (excluding any other expenses, eg. airline flights, hotels, meals, etc.).

$5,000.00/day (for any part of a day), for my appearance at trial or arbitration in Orange County, California. Appearing anywhere outside of Orange County, California, will include travel time at $600.00/hour, not to exceed $5,000.00/day, (excluding any other expenses, eg., airline flights, hotels, meals, etc.).

Please be advised of the following agreement:

Upon the closing, dismissal, settlement, etc., of any case in which I have been retained and not informed that my services are no longer required within 30 days of these issues and therefore have continued to retain the case as “open” in my files for which I have not yet billed for services rendered, your firm/company and or responsible agent will be responsible for payment in full.

Firm/Company and responsible agent agreement and date:

_____ date_____

Richard L. Ruffalo, M.D. date:

_____date_____

Exhibit K

Exhibit K

June 14, 2021

Adam Garth, Esq.
Lewis Brisbois
6385 South Rainbow Blvd., Suite 600
Las Vegas, Nevada 89118

Re: Estate of Rebecca Powell vs. Valley Health System, LLC (dba) Centennial Hills Hospital Medical Center

Dear Mr. Garth,

At your request I have reviewed the following documents:

1. Rebecca Powell's Centennial Hills Hospital records CHH00001-01166;
2. Ms. Powell's autopsy report;
3. Toxicology report of the decedent Rebecca Powell from Centennial Hills Medical Center;
4. Plaintiffs' Complaint and associated medical affidavit of Sami Hashim, MD regarding his assertion that the "administering the drug (Ativan) several times IV-Push in a respiratory compromised patient, inclusively & directly led to the patient's wrongful death."

I utilized these records and reports to facilitate my analysis whether it was appropriate to use and titrate of small doses of lorazepam (Ativan) in order to alleviate Ms. Powell's continuing anxiety, over approximately 31-33 hours prior to her death.

As you know, my background is not only as a physician but also as a clinical pharmacologist and an assistant clinical professor of anesthesiology and critical care at the David Geffen/UCLA School of Medicine. I am a physician licensed to practice medicine in California. As listed in my curriculum vitae (Exhibit 1), I have been an assistant clinical professor of anesthesiology at the David Geffen/UCLA School of Medicine continuously since 1991. In addition, I have in the past, also been an assistant clinical professor of Family Practice Medicine at Loma Linda University School of Medicine and an assistant clinical professor of Clinical Pharmacy and Clinical Pharmacology at the USC School of Pharmaceutical Sciences. I am board Certified in Anesthesiology and am a Fellow of the American College of Clinical Pharmacology. I obtained my M.D. degree in 1988 and my PharmD. in 1977. My clinical and academic practice is in anesthesiology, critical care and clinical pharmacology. As a clinical pharmacologist, I am called upon to evaluate patients regarding diverse medical and pharmacologic and toxicologic problems in various hospital settings (e.g., ED, ICUs, Med/Surg., Psych., etc.). I have been qualified as an expert witness in the states of California, Nevada, Alaska, Hawaii, Maryland, and Arizona. I have also been qualified as an expert witness in Federal Court. I have served as a consultant and expert for the California Medical Board. I have also served as an expert for the office of the U.S. Attorney in various states. I have also trained medical residents and fellows and personally cared for patients such as Ms. Powell having the same or similar circumstances and utilized lorazepam to treat anxiety to minimize anxiety and agitation driven tachypnea/hyperventilation issues to decrease the work of breathing and allow patients to tolerate face masks and/or CPAP and BiPAP oxygenation and therefore minimize the need for intubation and mechanical ventilation. My opinions contained herein are made to a reasonable degree of medical based upon my knowledge, experience and training.

Based upon the medical records Ms. Powell was admitted to Centennial Hills Medical Center Emergency Department at 03:27. May 3, 2017, due to an overdose of Benadryl, Cymbalta and Ambien and possibly ETOH according to the EMS report. The ED physician's diagnoses were respiratory failure, low BP, sinus tachycardia and acidosis. The patient was then intubated and mechanically ventilated and admitted to the ICU. In order to minimize the stress, agitation and pain and gaging when mechanically intubated and ventilated Ms. Powell was titrated and started on continuous infusions of the anesthetic drug propofol and the sedative/hypnotic drug midazolam. Both propofol and midazolam are very potent GABA(a) agonists that bind to the GABA(a) receptors in the central nervous system (e.g., the brain and spinal cord). Depending on the dose and potency, GABA(a) agonists induce sedation, decrease agitation, create amnesia, analgesia and decrease respiratory drive and the stress responses of elevated heart rate and hypertension. Lorazepam (Ativan) and Ambien (zolpidem) are less potent GABA(a) agonists and are given at much smaller doses primarily to decrease anxiety and create minimal to very mild sedation and have a minimal effect on respiratory drive. When a moderate single dose of lorazepam 2 mg is given to drug naïve patients it results in a minimal to mild decrease respiratory function. The effects of respiratory depression of both lorazepam and zolpidem even in significantly large overdoses that result in deep sedation rarely require the need for supplemental oxygen. More importantly, patients who take chronic doses of lorazepam and zolpidem will develop tolerance within 1-2 weeks, especially to the sedative and respiratory depressant effects. This tolerance to the sedative and respiratory effect of lorazepam (and other benzodiazepines; alprazolam, diazepam, temazepam, flurazepam, oxazepam, etc.) engendered the FDA to state that lorazepam and other benzodiazepines to not be used to treat insomnia for more than two weeks due to tolerance and possible addiction.

Of major importance, Ms. Powell's post-mortem toxicology report only noted duloxetine (Cymbalta) present and no other medications due to not having enough blood to analyze. However, it must be noted that that there were empty bottles recently filled of both duloxetine and zolpidem. Therefore, one cannot state that Ms. Powell did not also have both Ambien and Benadryl in her blood at the time of admission and it is likely that she did in fact overdose on Ambien and Benadryl as well.

Significantly, Ambien was prescribed to Ms. Powell and that she most likely was not only taking it for insomnia and possibly anxiety as well, but that Ambien (zolpidem) is a GABA(a) agonist, similar to other GABA(a) agonists: Ativan (lorazepam), propofol and midazolam by binding to the GABA(a) receptors in the central nervous system. It is also likely that her chronic use of Ambien would lead to tolerance to its GABA(a) agonist effects. Small doses of GABA(a) agonists will lead to tolerance within one to two weeks. It has even been demonstrated the drug naïve subjects given a single average dose of a GABA(a) agonist will lead to a mild acute tolerance in a dose and potency manner due to rapid down regulation of GABA(a) receptors. However, it is well known that large doses of much more potent GABA(a) agonists propofol and midazolam while in the ICU would also cause very significant rapid tolerance within less than a week due to the downregulation and a decrease the number of cell membrane GABA(a) receptors. When either propofol or midazolam is discontinued, patients commonly have mild to moderate "withdrawal" affects within a couple of days, such as having difficulty sleeping, anxiety and sometimes jitteriness and agitation and need to continue low doses of a GABA(a) agonist most often lorazepam, to control these withdrawal side effects. However, when both propofol and midazolam are given together in the ICU it is very common that patients will have even more tolerance and side effects from tolerance/withdrawal of these potent GABA(a) agonists. With low doses of GABA(a) agonists the tolerance will dissipate within a one to two weeks. With larger doses and more potent GABA(a) agonists it can take from two to three weeks or more to dissipate.

Considering that the last doses of both propofol and midazolam were stopped about 3 ½ days prior to the patient developing moderate anxiety and mild respiratory problems on the afternoon of May 9, 2017. Of note, the half life of midazolam is normally 3 to 5 hours [with a single dose] but will be up to 6 to 8 hours [with continuous infusions over a few days especially when it is given simultaneously with propofol which inhibits the metabolism of midazolam]. The definition of a drug's half-life is the time it takes for a drug to be metabolized or excreted by 50%. Therefore, if a drug's half life is 8 hours, 50% is eliminated; in another 8 hours another 50% of the original 50% is eliminated which is 25%; during the next 8 hours only half of the 25% remains = 12.5%, next 8 hours 6.25% remains, next 8 hours 3.125% remains; the next 8 hours only 1.75 remains. Based upon the study of pharmacokinetics and metabolism, after 6 half-lives less than 1 % of a drug would remain. Therefore, if we assume that midazolam has an 8-hour half-life then after 6 half-lives = about 48 hours or two days less than 1% of midazolam remains.

Propofol's half-life is only 1.5 to 4 hours after a single dose. However, the longer and greater the amount of propofol that is infused the longer the metabolic half-life. Studies have demonstrated that after a ten-day infusion, the half-life is between 24 to 72 hours versus shorter infusion times of 3 to 5 days the half-life is between 12 to 18 hours. Therefore, after 3 ½ days of a propofol infusion, and using a half-life of 12 hours hours then after 6 half-lives = 72 hours, less than 1% of propofol remains in the body.

Based upon Ms. Powell's overdose of Cymbalta (duloxetine) the ante-mortem blood that was drawn in the hospital on 5/05/2017 at 04:00 AM versus her admission date of 5/03/2017 about 03:00 AM was found by EMS at about 02:30 AM, about 48 hours after her multidrug overdose. Ms. Powell's duloxetine blood level was 200 ng/ml (which is the same as 0.2 mg/L) which is more than 10 times greater than therapeutic blood levels of 0.023 mg/L – 0.08 mg/L. The half-life of duloxetine between 8-17 hours and using an average of 12 hours means that after 6 half-lives = 72 hours less than 1% of duloxetine remains in the body. Ms. Powell's psychiatric history is that of depression/anxiety and insomnia. Duloxetine is a SNRI anti-depressant meaning that it binds both the serotonin and norepinephrine reuptake receptors which allows it to better treat both depression and anxiety than SSRIs. Unfortunately, when there is an abrupt discontinuation of duloxetine there will be an abrupt return of depression, anxiety, agitation and insomnia which is termed antidepressant "withdrawal." Therefore, between 5/05/2017 and 5/09/2017 Ms. Powell is having anxiety, which required the physicians' order of the first dose of lorazepam 0.5 mg that was given 16:09 PM and to be repeated every 8 hours as needed.

What is also important is that it took two days or less for both the propofol and midazolam to be clinically insignificant. It is now that the rapid onset of tolerance/withdrawal effects will begin to manifest. Thus, the very next day in the afternoon of May 9, 2017, Ms. Powell begins to develop anxiety similar to the above withdrawal of duloxetine and therefore the need to treat anxiety with 0.5 mg of lorazepam. This was followed with another dose of lorazepam 0.5 mg IV push at 00:28 (28 minutes after midnight on 5/10/2017).

At 15:15 in the afternoon of 5/10/2017, Ms. Powell's partial vital signs were as follows: Oxygen saturation of 97% on only 3 liters/min of oxygen by nasal cannula, which is about only 25-26% oxygen (versus room air oxygen at 20.5% oxygen), her respiratory rate was 18 (which is normal), and heart rate of 95/min. which is normal especially in a patient with anxiety. At 16:01 5/10/2017, a third dose of lorazepam 0.5 mg IV push was given in the afternoon to treat anxiety. Based upon the minimal amount of supplemental oxygen and an oxygen saturation of 97% and respiratory rate of 18, it becomes clear that Ms. Powell developed tolerance/withdrawal induced anxiety and is not displaying any clinically

significant sign of hypoxia or respiratory decompensation or distress. It is important to note that when lorazepam is given IV push the peak effects in the brain occur within about 5 minutes. Approximately 25 minutes after the third 0.5 mg of IV push lorazepam and its peak effects, Ms. Powell's ABG (arterial blood gas) drawn at 16:32 5/09/2017, showed the following: pH7.37, PaCO2 30.2 mm/hg, Pao2 of 89 mm/hg, HCO3 17.4, O2 SAT of 97% on 3 liters/min of oxygen. These above levels demonstrate that there was no lorazepam induced hypoxia, and only mild metabolic acidosis and very mild hypocarbia due to her anxiety and possibly to offset the mild metabolic acidosis. Furthermore, there was no tachypnea (increased respiratory rate) at this time.

However, there was a respiratory therapist progress note at the same time of 16:32 on 5/10/2017, as the above ABG. The note stated that the patient (Ms. Powell) went to get a chest CT – but became SOB (short of breath) during radiology with the rapid response team called and noted a heart rate of 115/min., respiratory rate of 28/min. However, the above ABG results only demonstrate mild metabolic acidosis (lactic acidosis likely due to her increased anxiety and work of breathing) and hypocarbia with a possible uncharted increased respiratory rate. It is very likely that the combined acute withdrawal of duloxetine and propofol and midazolam led to what one might surmise that Ms. Powell was frightened by being put into the CT Scanner and became very anxious and agitated with hyperventilation and calmed down when taken back to her room as the partial vital signs taken the following times: 19:19 heart rate 95/min. and respiratory rate 17/min; at 19:47 and19:54 heart rate 99/min and respiratory rate 16/min; at BP 142/77, heart rate 95/min., respiratory rate of 18. The nursing note by Michael Pawlak RN, indicate that the "Pt complained of SOB during any movement between bed and bedside commode from the beginning of shift at 19:00. RT responded to requests to assess and perform breathing treatment (PRN per MAR), and pt indicated some relief from treatments."

The next partial set of vital signs were taken at 23:51, 5/10/2017: heart rate 102 (mild tachycardia), which was followed at 00:10 5/11/2017: heart rate 101/min, O2 sat 95% on 3 liters/minute of oxygen, respiratory rate of only 20/minute. These vital signs are indicative of no more than mildly- moderate respiratory decompensation as well as the of withdrawal effects from duloxetine, propofol and midazolam. Therefore, the treatment in patients with mildly-moderate respiratory decompensation with concurrent anxiety supports the need for low doses of lorazepam to minimize Ms. Powell's anxiety and decrease her work of breathing and fatigue. Unfortunately, due to Ms. Powell's long-term use of Ambien (zolpidem) and duloxetine and recent use of large doses of propofol and midazolam Ms. Powell was very tolerant to the effects of lorazepam. Each of the three 0.5 mg doses of lorazepam were of a mild benefit to treat her anxiety without any significant respiratory depression. Therefore, the combined prior three doses of lorazepam also had minimal effects upon her respiratory function.

Nurse Powlak continued: "However, pt continued to state some SOB was present, and a stat CT Angio Chest was ordered at 02:00. Pt asked for Ativan (PRN per MAR, 0,5 mg), given at 02:20. Pt was transported to CT at approx. 02:30. At approx. 02:40, CT called to state that the pt was returning to the room (&) and the CT could not completed (sic) due to pt's complaints of SOB and anxiety. The charge nurse (Karen) was asked to assist in assessing the pt, and she attended the pt at the bedside. The pt stated she felt short of breath and that the Ativan she received was not effective. A page was made to Dr. Concio shortly afterward to discuss the pt's complaints. He returned the call, which was taken by Karen. A one-time additional dose of (Ativan 0.25 mg) was approved by Dr. Concio and administered by Karen at 0327. It appeared to be somewhat effective in calming the pt. RT was again called to assess the pt, and the RT tech (Venessa) indicated that the pt was not cooperating with the respiratory assessment and treatment, removing the mask repeatedly. Vanessa also stated that the pt needed to be monitored by a "sitter."

Even after the above four 0.5 mg doses of lorazepam Ms. Powell remained significantly agitated and anxious and that in order to try to allow her to tolerate the mask on her face the last a small 0.25 mg dose of Ativan (lorazepam) was indicated.
Similar to the above note by nurse Pawlak, a nursing note by Karen Valdez, RN on 5/11/2013 3:15 PDT: "Into see patient with Primary RN, Michael P. Patient is very anxious, states she is having hard time breathing. Respiratory notified and will come up. Paged Dr. Concio for additional dose of Ativan to help patient relax. Order received for Ativan 0.25 mg IVP one. Patient medicated per orders. Vanessa, RT, states patient keeps pulling her oxygen off and need to be monitored closely.

Nurse Pawlak nursing note also stated: "From approx. midnight, the pt repeatedly stated "I can't do this anymore," and that "it isn't worth it." However, she did eventually calm down, and her breathing appeared less labored (approx. 0415). At approx. 0610 the pt was found sitting in her bed, unresponsive, with the oxygen mask at her feet."

Overall, it should be noted that 40 minutes after the last small 0.25 mg dose of lorazepam given 03:27 Ms. Powell's blood and brain levels had already peaked at 03:35 and she eventually calmed down and her breathing appeared less labored at (approx 0415). Despite the combined doses and of the blood levels of lorazepam, Ms. Powell continued to be anxious and agitated and continued pulling off her oxygen mask and was found dead two hours later. Therefore, I can state with a reasonable degree of medical certainty that the multiple doses of lorazepam were not contributory to Ms. Powell's death.

Richard Ruffalo, MD, PharmD, FACCP

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DISTRICT COURT

CLARK COUNTY, NEVADA

ESTATE OF REBECCA POWELL, through BRIAN POWELL, as Special Administrator; DARCI CREECY, individually and as Heir; TARYN CREECY, individually and as an Heir; ISAIAH KHOSROF, individually and as an Heir; LLOYD CREECY, individually;, Plaintiffs, vs. VALLEY HEALTH SYSTEM, LLC (doing business as "Centennial Hills Hospital Medical Center"), a foreign limited liability company; UNIVERSAL HEALTH SERVICES, INC., a foreign corporation; DR. DIONICE S. JULIANO, M.D., an individual; DR. CONRADO C.D. CONCIO, M.D., an individual; DR. VISHAL S. SHAH, M.D., an individual; DOES 1-10; and ROES A-Z;, Defendants.	Case No. A-19-788787-C Dept. No. 30 **DEFENDANT CENTENNIAL HILLS HOSPITAL MEDICAL CENTER'S REBUTTAL EXPERT DISCLOSURE**

Defendant Valley Health System, LLC dba Centennial Hills Hospital Medical Center, by and through their attorneys of record, S. Brent Vogel, Esq. and Adam Garth, Esq. of Lewis Brisbois Bisgaard & Smith, LLP, hereby submits their Rebuttal Designation of Expert Witnesses and Reports, pursuant to NRCP 16.1 as follows:

1. Hiren Shah, M.D.
2730 North Dayton Street
Chicago, Illinois 60614

Dr. Hiren Shah is a retained expert witness who is expected to offer his expert opinions as to Rebecca Powell's (herein after referred to as "Decedent") alleged medical conditions resulting from the incident(s) and action(s) which are the subject of Plaintiffs' Complaint. Dr. Shah is expected to testify, *inter alia*, that the care and treatment provided to Rebecca Powell was within the applicable standard of care, consistent with his Report, and will further testify the acts of Centennial Hills Hospital Medical Center did not cause the damages alleged by Plaintiffs. Dr. Shah is also expected to provide opinions regarding the facts in this case as they relate to his medical specialties, which may include but are not limited to rebuttal testimony. Dr. Shah reserves the right to supplement and/or revise his Report as new information is provided. Additionally, Dr. Shah is expected to give rebuttal opinions response to other witnesses or experts designated in this matter. He reserves his right to supplement and/or revise his report as new information is provided.

Dr. Shah is certified by the American Board of Internal Medicine since 1999. Dr. Shah's CV, fee schedule, and testimony list were previously disclosed in Defendant's Initial Expert Disclosure. **Exhibit A** hereto is Dr. Shah's rebuttal expert report.

2. Abraham M. Ishaaya, M.D., F.C.C.P., F.A.A.S.M., F.A.C.G.S., M.A.C.G.S.
5901 West Olympic Boulevard, Suite 200
Los Angeles, CA 90036

Dr. Abraham Ishaaya is a retained expert witness and is expected to testify regarding his understanding of the facts and circumstances surrounding the subject complaint, standard of care, causation, medical treatment, prognosis, and costs of medical expenses. Dr. Ishaaya has been board certified by the American Board of Internal Medicine, Pulmonary Medicine, Sleep Medicine, and Geriatrics. Dr. Ishaaya's CV, fee schedule, and testimony list were previously disclosed in Defendant's Initial Expert Disclosure. **Exhibit B** hereto is Dr. Ishaaya' s rebuttal expert report.

Dr. Ishaaya is expected to testify, *inter alia*, that the care and treatment provided to Rebecca Powell by Centennial Hills Hospital Medical Center was within the applicable standard

of care, consistent with his Report, and will further testify the acts of Centennial Hills Hospital Medical Center did not cause the damages alleged by Plaintiffs. Dr. Ishaaya is also expected to provide opinions regarding the facts in this case as they relate to his medical specialties, which may include but are not limited to rebuttal testimony. Dr. Abraham Ishaaya reserves the right to supplement and/or revise his Report as new information is provided.

3. Richard Ruffalo, M.D., Pharm.D., M.A., F.A.C.C.P.
   11 Sea Shell
   Newport Coast, California 92657

Richard Ruffalo, M.D. is a retained expert witness and is expected to testify regarding his understanding of the facts and circumstances surrounding the subject complaint, standard of care, causation, medical treatment, prognosis, and pharmacology. Dr. Ruffalo has been a member of Alpha Omega Alpha, National Medical Honor Society since 1986. Dr. Ruffalo's CV, fee schedule, and testimony list were previously disclosed in Defendant's Initial Expert Disclosure. **Exhibit C** hereto is Dr. Ruffalo's rebuttal expert report.

Richard Ruffalo, M.D. is expected to testify and to provide opinions regarding the facts in this case as they relate to his specialties including the pharmacology issues alleged by Plaintiffs, which may include but are not limited to rebuttal testimony. Richard Ruffalo, M.D. reserves the right to supplement and/or revise his Report as new information is provided.

4. Erik Volk
   1155 Alpine Road
   Walnut Creek, CA, 94596

Erik Volk is a retained expert witness and is expected to testify regarding his understanding of the facts and circumstances surrounding the subject complaint, and costs of medical expenses as well as the past and future earning capacity of Decedent and the economic costs associated with her death. Mr. Volk specializes in valuation of economic losses in businesses, personal injury, wrongful death, and labor litigation. Mr. Volk's CV, fee schedule, and testimony list were previously disclosed in Defendant's Initial Expert Disclosure. **Exhibit D** hereto is Mr. Volk's rebuttal expert report.

Mr. Erik Volk is expected to testify and to provide opinions regarding the facts in this case

as they relate to his specialties including the economic losses alleged by Plaintiffs, which may include but are not limited to rebuttal testimony. Erik Volk reserves the right to supplement and/or revise his Report as new information is provided.

Defendants specifically reserve the right to designate any witnesses designated by any party. Defendants further reserves the right to supplement this list as any witnesses become known through the course of discovery.

DATED this 27th day of August, 2021.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By */s/ Adam Garth*

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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of Lewis Brisbois Bisgaard & Smith LLP and that on this 27th day of August, 2021, a true and correct copy of **DEFENDANT CENTENNIAL HILLS HOSPITAL MEDICAL CENTER'S REBUTTAL EXPERT DISCLOSURE** was served electronically using the Odyssey File and Serve system to all parties with an email-address on record, who agreed to receive electronic service in this action, as follows:

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By /s/ *Roya Rokni*
an Employee of
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Exhibit A

Exhibit A

Northwestern Memorial® Hospital

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211 E Ontario Street 7th Floor
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Phone: 312.926.3681

August 24, 2021

Adam Garth
6385 South Rainbow Blvd., Suite 600
Las Vegas, NV 89118

Dear Mr. Garth:

Thank you for the opportunity to provide additional information and responses to defense expert reports in the case of Ms. Rebecca Powell who was admitted to Centennial Hills Hospital on 5/3/2017. Please find this report a supplemental report to my initial case summary and analysis and opinions provided in a report dated 6/5/2021 after having reviewed the following additional items in this case: Expert reports by Dr. James Leo, Dr. Thomas Cumbo, Dr. James Lineback, Dr. Kenneth Stein, and Mr. Michael Griffith. I provide the following rebuttal to the aforesaid reports. All opinions provided herein are to within a reasonable degree of medical probability.

Ms. Powell was admitted on 5/3/17 with respiratory failure after drug overdose with her clinical course attributed to aspiration pneumonia due to MRSA based on sputum cultures. A bronchoscopy was performed 5/4/2017 and she was managed by pulmonary medicine and antibiotics were managed by infectious disease. As noted, after extubation on 5/6/2017, she was improving. On 5/10/2017, she began to have leukocytosis and her antibiotics were broadened to IV cefepime and zyvox. Her shortness of breath was appropriately attributed with progression on her underlying aspiration pneumonia. She was saturating at 93% on room air during Dr. Vishal Shah's evaluation at 13:16 on 5/10/201. After he was contacted about shortness of breath symptoms, he appropriately ordered a chest Xray and an arterial blood gas which showed a preserved pH of 7.37 while on 6L of oxygen. Despite receiving a dose of Ativan at 16:01, vital signs and ABG results at 16:32 do not indicate any respiratory depressant effects of the Ativan. After a chest Xray, she was then seen by Gary Skankey from infectious disease at 17:05 and Dr. Christopher Breeden from pulmonary medicine at 17:12. Although she had shortness of breath due to her known aspiration pneumonia, neither consultant determined Ms. Powell to be unstable or in need for a higher level of care. Appropriately, antibiotics were broadened, and a chest CT scan was ordered. At 22:22, she was on 3L of oxygen at 92% saturation and on 3L oxygen saturation 95% at 00:10. Respiratory assessment at 22:22 also supported continuing care on the medical floor by providing nebulizer therapy.

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RN Pawlak's note of Ms. Powell having shortness of breath with movement supports the clinical course of a patient with pneumonia. It was then appropriate to provide Ativan at 02:20 given Ms. Powell's anxiety so she could proceed with the chest CT. Ms. Powell requested the Ativan dose as indicated in RN Pawlak's note. Subsequently, Ms. Powell's shortness of breath at the time of the CT scan was expected as patients with pneumonia complicated by secretions often have difficulty lying flat and often report shortness of breath symptoms. In addition, the record indicates that along with shortness of breath, she as anxious at the time of the CT scan and could not complete the scan.

After returning from the CT scan, once again RN Valdez indicates that Ms. Powell was very anxious. After a second dose of Ativan was given at 03:27 as ordered by Dr. Concio, Ms. Powell was seen by the respiratory therapist who did not escalate care based on her respiratory assessment of the patient. Her main concern was Ms. Powell's cooperation with nasal canula use. At 03:15, the respiratory therapist indicated in her note that Ms. Powell's anxiety was causing her to remove her nasal canula and to facilitate oxygen delivery, a face mask was used.

In his report, Dr. Cumbo indicates that at 4:08 AM, the oxygen saturation dropped to 90% on a nonrebreather mask. Although factually correct that the saturation was 90%, the mask was only placed to facilitate oxygen delivery and not used as escalation of oxygen amount due to hypoxia from a worsening clinical condition on nasal canula as is suggested by Dr. Cumbo. Her drop in saturations correlated with anxiety and hyperventilation preventing appropriate oxygenation in a patient with ongoing pneumonia. There was no indication to notify physician staff as multiple follow-up assessments by nursing staff showed clinical stability. There was an evaluation by nursing staff or hospital support staff during multiple visits subsequent to this time in question. At 4:15 AM, the nurse noted the patient was calm. At 4:18 AM, the patient received a nebulizer treatment. At 5 AM she was seen by the CNA who noted the patient was okay. Vital signs were also obtained at 4:47 AM which although demonstrated tachycardia, was most likely due to her recent nebulizer treatment. In addition, anxiety likely contributed to her respiratory rate of 30. She was seen on the video camera at 5:10 AM sitting up and the L2 K records indicate she was seen on camera at 6 AM which was 10 minutes prior to her code event. Thus, during all of these patient encounters, it was apparent that Ms. Powell was stable and although she had ongoing significant respiratory infection, there was no indication to require a physician assessment, transfer to a higher level of care, or initiating a rapid response call.

Dr. Cumbo indicates that hospital protocol requires that an RRT should be called for shortness of breath with acute mental status change. However, patients often have shortness of breath and

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each of those instances where this complaint is reported is not an indication for an RRT. Similarly, a patient's mental status is difficult to assess in the early morning hours, and there is no indication that she was disoriented but was instead anxious and non-cooperative. The decision to call a rapid response team is based on nursing experience and training as well as RN assessment and judgment. In this situation, the staff's actions were appropriate and did not warrant notification to physicians or the rapid response team.

Dr. Cumbo indicates that the rapid response team would have stabilized her condition. However, the clinical record indicates that at 4:15 AM, the nurse noted that the patient was calm and at 5 AM she was seen by the CNA and noted to be stable. Thus, a rapid response team was neither required to assess the patient nor would there have been an alteration in the treatment plan. Dr. Cumbo also indicates that the rapid response team would have done appropriate imaging, that her respiratory condition required monitoring in the ICU and treatment with pharmacotherapy. Although patients can be monitored more closely in an ICU setting, for the reasons stated above, there was no indication to transfer Ms. Powell to the ICU such that she required closer monitoring. She was evaluated on the L2 K system and was seen at 5:10 AM and at 6 AM. In addition, as indicated earlier in this report, she was seen by multiple care providers during these early morning hours and was appropriately monitored. At 04:00, a pain assessment was completed. At 04:08, vital signs were obtained. At 04:15, RN Pawlak indicates that Ms. Powell was calm. At 04:18, a respiratory treatment is underway by the therapist. At 04:47, the respiratory treatment is completed by the therapist. At 05:00, a CNA does bedside rounding and indicates that Ms. Powell was ok. The basis for Dr. Cumbo's opinion that Ms. Powell required an RRT call is due to her elevated HR and respiratory rate but he fails to take into consideration what was happening to the patient (nebulizer therapy and ongoing anxiety symptoms) and fails to consider that multiple care providers assessed Ms. Powell in her room (at six points in time between 04:00 to 05:00) and all appropriately determined that she was stable and did not require escalation of treatment.

In regard to the criticism that the rapid response team would have done appropriate imaging, provided respiratory support and pharmacotherapy, there is no basis to support this criticism. Ms. Powell already had evidence of bilateral infiltrates earlier that evening and did not require additional imaging. The CT scan was attempted at 2 AM but could not be completed due to the patient's anxiety but the basis for this study was to evaluate for a pulmonary embolism which we know Ms. Powell did not have based on her autopsy results. In addition, even if another chest x-ray was done, it would have had no meaningful effect in changing the treatment course. She was already receiving respiratory support and had a nebulizer therapy at 4:18 AM by the respiratory

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services who did not feel needed escalation of care. Furthermore, she was already on adequate pharmacotherapy which was being delivered intravenously.

Dr. Cumbo indicates that anxiety is a diagnosis of exclusion once other causes of dyspnea have been evaluated. In Ms. Powell's case, her dyspnea was appropriately attributed to pneumonia and thus her tachycardia and elevated respiratory rates were appropriately attributed to anxiety symptoms. Dr. Cumbo indicates the benzodiazepines likely suppressed Ms. Powell's respiratory drive but as noted extensively my initial report, an elevated respiratory rate of 30 does not support evidence of respiratory depression from benzodiazepines. In addition, the last dose of Ativan was given at 3:42 AM which was 3 hours and 47 minutes prior to the code event and if there was respiratory depression, it would have manifested itself within an immediate time period given the rapid onset of action of iv Ativan. Thus, there is no evidence that Ativan led to respiratory depression or was the cause of respiratory failure and subsequent code. Ms. Powell's decompensation was rather due to pneumonia and acute mucous plugging that led to her sudden event at 06:15 as supported by the large mucus plug removed at time of intubation. Dr. Cumbo indicates that it is uncommon to have clinical worsening after an initial improvement on antibiotics. However, there is significant patient heterogeneity in regard to response to antibiotics and a patient's specific clinical course. Patients can have improvement initially and can then worsen over time. In addition, a mucous plug is an additive event that leads to acute hypoxia and immediate respiratory failure which is independent of the association of clinical worsening and antibiotic therapy.

Dr. Cumbo's reference to identification and care of a patient at risk for suicide in the acute care setting is not interpreted appropriately in his report. The patient's suicide attempt was prior to admission and she was not demonstrating ongoing suicidal ideation which would place her at high risk for self-harm. Ms. Powell did not show a change in behavior as related to suicidal ideation in any way and did not require a sitter for this reason.

In summary, I disagree that Ms. Powell's situation was preventable. She had a pneumonia that was progressive but adequately treated on the medical floor until she had an acute mucous plug superimposed on her pneumonia at 6:10 AM that led to her code blue event. Her monitoring was appropriate, physician notification was not required and would not have change the plan of care and a rapid response was not necessary for the reasons outlined above.

Similarly, Dr. Lineback's statement that Ativan led to respiratory suppression is not supported by the facts in this case. As indicated in my initial report, the Ativan dose was last given at 3:27

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AM which was almost 3 hours and 45 minutes prior to her code blude event. There is no evidence of a temporal association between the two given the rapid onset of action of Ativan. Ms. Powell's respiratory rate was in the 30s which does not support respiratory suppression. This respiratory rate was elevated due to anxiety and was appropriately treated by Ativan which was given at very low doses.

Dr. Lineback claims that the patient was complaining of shortness of breath and not cooperating with respiratory assessments and removing her mask repeatedly and saying" I can't do this anymore and it's not worth it". This clinical course and her statements do not support that the standard of care was violated. Shortness of breath is expected in a patient with ongoing pneumonia. There was no labored breathing at 4:15 AM after her anxiety improved. There was no excessive sedation based on Ms. Powell's vitals, documentation by staff, and numerous bedside assessments by the providers in this case. In addition, even if Ms. Powell was not perfectly visible as suggested on the video monitor, this referred to her nasal cannula. One, however, would be able to assess for distress and a change in condition and L2K signatures at 05:00 and 06:00 supported stability.

Although it is correct that Ms. Powell had progressive pneumonia and an elevation of WBC count, Dr. Lineback inappropriately refers to this as deterioration such that a higher level of care was needed. Although she may have been short of breath, this is not unexpected given the patient had pneumonia. Dr. Lineback then states that the entries from the medical record describe a classical presentation of hypoxia where a normal response is anxiety and lack of cooperation including removing masks. A saturation of 90% early that morning prior to the code event and a normal PO2 on an ABG late the day prior does not support profound hypoxia such that a patient was demonstrating a change in mental status and lack of cooperation. Dr. Lineback further states that it's inappropriate to treat with a drug that further suppresses respiratory drive. As indicated above and in my initial report, there is no indication of any respiratory suppression by Ativan. In addition, an arterial blood gas was not indicated at the time of event in question as the patient was stable. The respiratory therapist also did not find a need to escalate care or to obtain an ABG at the time she began the nebulizer therapy at 04:08 or completed the treatment at 04:47. The standard of care was not violated by Dr. Concio in providing Ativan given her anxiety symptoms even though her pneumonia was ongoing and clinically more prominent on the 10th. Similarly, Dr. Shah did not violate the standard of care in the use of Ativan. Dr. Lineback indicates that Ativan should not be given following an episode of acute respiratory failure that required endotracheal intubation and mechanical ventilation. There is no reasoning for this. After patients have been intubated and subsequently extubated, appropriate clinical judgment should

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guide the use of anti-anxiety medications and prior intubation and mechanical ventilation would not be exclusionary criteria for the use of such drugs.

As noted in Dr. Stein's report, Dr. Skankey and Dr. Breeden were not required by the standard of care to contemporaneously obtain vital signs at the time of patient evaluation. The standard of care however does require appropriate clinical decision making based on the diagnostic information a physician obtains at the time a patient is evaluated which occurred in this case. I disagree with Dr. Stein's assertion that Ms. Powell was too unstable at the time of CT angiography to have the test. Although she did have shortness of breath, it is not unusual for patients who have pneumonia to have trouble lying flat due to significant pulmonary secretions. In addition, multiple RN and physician notes indicate that Ms. Powell had anxiety related symptoms in addition to shortness of breath which would be expected from her pneumonia.

There is no evidence that Ms. Powell's failure to cooperate with the respiratory assessment and treatment along with removing her mask was due to anything other than anxiety and agitation. Her hypoxia based on saturation was not profound enough to lead to level of non-cooperation. Even though it was discussed between the house supervisor and the camera monitor operator on moving Ms. Powell to a different room, her condition significantly stabilized as she calmed down and was less labored at 4:15 AM. Thus, her clinical condition no longer required any escalation of care for monitoring or change in room with different video capabilities.

Ms. Powell did have a worsening in her pneumonia with relative hypoxia and elevated WBC count with infiltrates on her chest x-ray as Dr. Stein indicates. As the evening progressed after Dr. Skankey's evaluation at 17:05, Ms. Powell was short of breath but was being adequately treated. There is no evidence that she needed increasing amounts of oxygen that could not be provided safely and appropriately on the medical floor. Respiratory therapy would be most experienced in understanding the need to escalate care and felt no need to do so aside from providing a face mask for more comfort rather than nasal cannula and providing nebulizer therapy while antibiotics were ongoing for her pneumonia. Nursing staff appropriately contacted the night physician who appropriately ordered Ativan for anxiety symptoms. Nursing staff also appropriately discussed Ms. Powell's condition with their supervisor and were discussing options to ensure Ms. Powell was getting appropriate care. Her condition improved by 4:18 AM and she did not require any change in her treatment plan or require transfer to higher level of care. As indicated in my initial report, there was no indication to transfer Ms. Powell to the intensive care unit. She did not require noninvasive ventilation or endotracheal intubation and mechanical ventilation as her condition had improved significantly and she was seen by care providers at

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04:00, 04:08, 04:15, 04:18, 04:47, and 05:00 and was found to be stable. Dr. Steinberg refers to the use of Lasix which could have been provided in Ms. Powell's case but her outcome would have been no different with Lasix which was not indicated. She did not require transfer to a higher level of care and the outcome would not have been any different based on any addition treatments had she moved to an intensive care unit setting.

Contrary to Dr. Stein's allegation, Dr. Concio was provided appropriate information regarding Ms. Powell's condition and had access to her medical record and appropriately ordered antianxiety medications. The Ativan that was prescribed had no impact in causing any respiratory depression or leading to her subsequent code blue event which was due to pneumonia complicated by an acute mucous plug.

In addition, Ms. Powell's vital signs, respiratory status, and symptoms of shortness of breath in an attempt to lie flat at radiology at the time of her CT represented her ongoing pneumonia and did not warrant a rapid response call as alleged by Dr. Stein.

At 4:08 AM, Ms. Powell's tachycardia and high respiratory rate were due to anxiety along with a subsequent nebulizer therapy. Her saturation of 90% was adequate and appropriate given her medical diagnosis. Ativan had no respiratory depressant effect as alleged by Dr. Stein. There is no indication for cardiac telemetry with continuous pulse oximetry nor would either have changed the outcome.

In addition, Ms. Powell had pneumonia as determined by the autopsy and did not have a pulmonary embolism. Thus, even if the CT angiography of the chest was done at 5:08 PM as suggested by Dr. Stein, it would have been negative for any acute thromboembolic event and would not have changed the treatment course.

The autopsy does not indicate congestive heart failure leading to edema or acute respiratory distress syndrome as Dr. Stein indicates but the autopsy finding does indicate Ms. Powell had pneumonia with significant secretion burden and clinically had acute mucous plugging.

I disagree with nurse Griffin's opinions that nursing staff at Centennial Hills Hospital failed to initiate a rapid response at 4:08 AM. Her oxygen delivery was changed from 3 L nasal cannula to a nonrebreather mask with a flow road to 15 L mainly for comfort and due to anxiety rather than for acute hypoxia from a change in her clinical condition. There is no evidence that the

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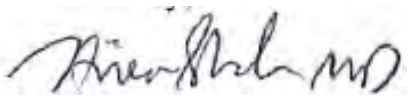
failure to visually monitor Ms. Powell led to her subsequent respiratory event or any delays in identifying her condition.

Thank you for allowing me to provide addition information to support the opinion in my initial report. All my opinions noted above are stated to a reasonable degree of medical probability. Please do not hesitate to contact me should you have any further questions.

Sincerely,



Hiren Shah, MD SFHM

Exhibit B

Exhibit B

Mr. Garth,

I was asked to respond to Plaintiff's expert allegations. My opinions stated below are to a reasonable degree of medical probability based on my experience and training. For convenience, I have added the main allegations for each of the experts. As previously noted in my original declaration, I am currently director of Western Convalescent Subacute Department, chief of medicine at Miracle Mile Medical Center, and Medical Director of the Respiratory Department at Southern California Hospital in Culver City, CA. Until recently, I was the director of respiratory therapy at Midway/Olympia Hospital in Los Angeles, CA which shut its doors. I obtained my medical degree from University of Maryland Medical School in 1990. I completed my residency in Internal Medicine at Cedars-Sinai Medical Center in Los Angeles from 1990-1993, followed by a fellowship in pulmonary and critical care medicine at Cedars-Sinai from 1993-1996. I am quadruple boarded in Internal Medicine, Pulmonary Medicine, Sleep Medicine and Geriatrics. I also hold the title of Assistant Clinical Professor of Medicine at the UCLA School of Medicine. A copy of my curriculum vitae outlining my qualifications, educational background and related employment was attached to my original declaration and is incorporated herein.

Dr. Thomas Cumbo:

Assessment and Rationale:

As noted by the State of Nevada/Department of Health and Human Services/Division of Behavioral Health/Bureau of Health Care Quality and Compliance's investigation, Centennial Hills Hospital Medical Center did not respond to Ms. Powell's respiratory distress and failed to upgrade her to a higher level of care (complaint # NV 00049271). Ms. Powell clearly demonstrated worsening respiratory failure over the course of approximately 27 hours which ultimately resulted in acute cardiopulmonary arrest. Her autopsy confirmed severe aspiration pneumonia. There was plenty of opportunity to assess and stabilize Ms. Powell before she died. If the Rapid Response Team Policy (last updated 12/2016) were followed, the patient would more likely than not been afforded care that would have stabilized her condition. Section II, part A indicates that two reasons for calling a Rapid Response include acute mental status change and shortness of breath. Both applied in this situation. A Rapid Response would likely have included, but would not be limited to, appropriate imaging, respiratory support, closer monitoring in an ICU setting and pharmacotherapy. Instead, imaging attempts were aborted and she was treated with benzodiazepines without a proper assessment. Although anxiety was in the differential diagnosis, it is a diagnosis of exclusion only to be assigned after a proper work up and evaluation for more exigent causes of her dyspnea. Instead, the benzodiazepines likely suppressed her respiratory drive and hampered her ability to compensate for a worsening pneumonia. Staphylococcus aureus pneumonia can take weeks to completely clear especially after a large aspiration event. It is not uncommon to have clinical worsening after an initial improvement on antibiotics.

Additionally, the policy "Identification and Care of the Patient at Risk for Suicide in the Acute Care Setting (last updated 02/2016)" was also ignored. She was clearly a high-risk patient having been admitted with a near fatal suicide attempt (section IV- Assessment). More importantly, however, is that according to section VII (Patient Safety Instructions), subsection 4.g. "the safety attendant should notify the assigned nurse immediately for any change in behavior." Clearly this did not occur because the patient was not visualized for over one hour despite the attendant's request to have the patient moved to another room for unimpeded

visualization.

In summary, this unfortunate situation was preventable. Multiple policies were ignored and the patient's respiratory failure was misdiagnosed. If proper monitoring was in place, physicians were notified appropriately, a Rapid Response was called, and the patient was properly assessed I am of the opinion Ms. Powell would not have died that morning.

My response to Dr. Cumbo's opinions:

Centennial Hills Hospital Medical Center staff did respond to Ms. Powell's respiratory distress. A rapid response was called earlier that evening, and she had ongoing monitoring thereafter. She was receiving IV antibiotics, IV steroids and adequate oxygen to maintain a saturation of 90% or above and was repeatedly assessed throughout the night.

Ms. Powell was monitored throughout the night and was noted to be oxygenating adequately prior to her cardiopulmonary arrest. It is highly unlikely that a transfer to the ICU would have changed her course, as she likely progressed to fulminant ARDS, as a direct result of her initial aspiration event, not from anything which Plaintiffs allege any defendant did or failed to do in this case. Likewise, the nurses and physicians were aware of and monitored her status throughout the night, and it is also highly unlikely that another rapid response would have changed her overall outcome, since a rapid response was called several hours prior, and she was already receiving all of the appropriate medical interventions. It is my opinion to a reasonable degree of medical probability that no other interventions would have made any medically significant impact on her prognosis or chance of recovery.

Dr. James Lineback

Based on the fact pattern in this case and the information contained in these medical records, it is medically probable that this patient's death was related to respiratory suppression secondary to the administration of a benzodiazepine (Ativan) in the early morning hours of May 11, 2017. It was below the standard of care for this patient to be treated with a known respiratory suppressant in the face of a deteriorating clinical status which resulted in her continually complaining of shortness of breath and exhibiting classic signs of hypoxia. It is medically probable that this patient's death was a direct result of respiratory suppression due to treatment with intravenous Ativan, a known respiratory suppressant. It is also medically probable that had this patient been evaluated properly and intubated in the early morning hours of May 11, 2017, that her death would have been prevented.

My response to Dr. Lineback's opinions:

It is highly unlikely that the patient's death was in any way related to respiratory depression as result of the total doses of benzodiazepine used. The total amount given was minimal and would in no way suppress Ms. Powell's respiratory drive and lead to any significant CO2 retention or narcosis. It is not unusual in the acute setting to provide small doses of benzodiazepine to help with patients that are suffering from respiratory issues, as anxiety frequently occurs as a result of the underlying breathing difficulties. Based on my experience, the amount of Ativan given would not have caused Ms. Powell's

death, as much higher doses would have certainly been required to lead to any significant respiratory suppression.

Dr. Kenneth Stein

Throughout the day on May 10, 2017, and the early morning of May 11, 2017, Ms. Powell was showing signs and symptoms of worsening condition including respiratory distress (stating she felt like she was "drowning"), relative hypoxia requiring increasing amounts of oxygen, respiratory alkalosis from rapid breathing, elevated white blood cell count, anxiety, restlessness and increased interstitial markings on her chest X-ray. After being sent to radiology for a chest X-ray a "Rapid Response" was called because of respiratory distress. Dr. Breeden and Dr. Skankey both evaluated her within 1 hour after the rapid response. Dr. Skankey documented that at approximately 5:00 PM Ms. Powell on examination was "Acutely Dyspneic" (Short of Breath). As the evening progressed and Ms. Powell was requiring increasing amounts of oxygen and was becoming more anxious rather than calling for a physician to evaluate Ms. Powell the nursing staff increased the amount of oxygen being delivered and contacted Dr. Concio to request additional dose of Ativan to treat anxiety. When Ms. Powell was becoming more anxious and was pulling off her oxygen and not cooperating with breathing treatments nursing staff contacted the nursing supervisor David who recommended that instead of obtaining a "Sitter" to sit in the room and observe Ms. Powell (as requested by nursing staff ,respiratory therapy, and the monitor tech), or moving Ms. Powell to a room that had better abilities to monitor her via video, David recommended that instead restraints be placed on Ms. Powell's hands.
The autopsy showed significant findings in the lungs including extensive acute and chronic pneumonia with extensive pulmonary edema. In essence her lungs were filling with fluid and products of inflammation in addition to being damaged by the inflammation. These findings are consistent with her worsening symptoms of respiratory distress, anxiety, feeling like she was "Drowning", higher oxygen requirements, lower oxygen saturations, rapid breathing and rapid heart rate. However, her condition was treatable and if proper care had been provided then within a reasonable degree of medical probability, she would have survived this hospitalization. The indicated and proper medical treatment for these conditions would have included admissions to the intensive care unit, re-evaluation by a physician, respiratory /pulmonary treatments to be ordered at the discretion of the physician which may have included high flow oxygen, noninvasive ventilation or endotracheal intubation and mechanical ventilation. In addition, medications that may have been administered as indicated including furosemide, nebulizers and other medications as needed based on patients clinical course. The failure to transfer Ms. Powell to a higher level of care and the failure to provide these treatments as needed within a reasonable degree of medical probability were the immediate cause of her death.

On May 10, 2017 the treating physicians breached the standard of care by not transferring Ms. Powell to a higher level of care for further evaluation and treatment.
The nursing staff breached the standard of care if, on the early morning of May 11, 2017 when contacting Dr. Concio they did not provide an adequate history concerning Ms.

Powell's vital signs, respiratory status (including amount of oxygen delivered, oxygen saturation and respiratory rate), her rapid response earlier in the evening for respiratory distress and that she had been rushed back to the floor from radiology at approximately 2:40 AM as she was too unstable.

Furthermore, if the nursing staff did not specifically request for Dr.Concio to come to the bedside to evaluate miss Powell the nursing staff breached the standard of care.
If nursing staff did appropriately inform Dr. Concio of Ms. Powell's condition, Ms. Powell's vital signs, respiratory status (including amount of oxygen delivered, oxygen saturation and respiratory rate) rapid response having been called in radiology on the afternoon of May 10, 2017, and Ms. Powell being sent back emergently from radiology at 2:40 am because of inability to tolerate a CT scan secondary to respiratory distress and Dr.Concio did not either come to the bedside to evaluate Ms. Powell or order that a Rapid Response be activated but instead ordered Ativan to treat anxiety then Dr. Concio breached the standard of care.

Nursing staff breached the standard of care by not activating a Rapid Response at approximately 3:15 am on May 11, 2017 when Ms. Powell complained of anxiety, difficulty breathing and she was pulling off her oxygen. Instead they called D. Concio to request Ativan for anxiety.

Nursing staff breached the standard of care at 4:08 AM by not activating a Rapid Response when Ms. Powell's respiratory status had worsened to the point that she now required a Non-Rebreather mask to deliver oxygen, her heart rate had increased to 130 beats/min and her respiratory rate had increased to 30 breaths/minute and her oxygen saturation was only 90%. or at 4:40 AM when her heart rate was 140 beats/min.

Dr. Concio and nursing staff breached the standard of care by administering Ativan to decrease Ms. Powell's anxiety rather than having a physician or rapid response team re evaluate Ms. Powell's respiratory difficulties which within a reasonable degree of medical probability was the cause of her anxiety. Within a reasonable degree of medical probability, the Ativan that was administered worsened Ms. Powell's respiratory status.

The treating physicians and the nursing staff at Centennial Hills Hospital all breached the standard of care by not transferring Ms. Powell to a higher level of care that would have included reevaluation by a physician, cardiac telemetry, continuous pulse oximetry and either constant direct visual observation by a nurse/sitter or adequate constant observation via video camera with monitoring.

It was a breach of the standard of care at 5:08 pm on May 10th, 2017 for the CT Angiogram of the chest to have not been ordered on a STAT basis.

Within a reasonable degree of medical probability, the worsening of Ms. Powell's condition was secondary to worsening pulmonary status from either pneumonia, cardiogenic pulmonary edema or non-cardiogenic pulmonary edema/ARDS. The indicated and proper medical treatment for these conditions would have included admission to the intensive care unit, re-evaluation by a physician, respiratory /pulmonary treatments to be ordered at the discretion of the physician which may have included high flow oxygen, noninvasive

ventilation or endotracheal intubation and mechanical ventilation. In addition, medications may have been administered as indicated including furosemide, nebulizers and other medications as needed based on patient's clinical course.
If the above breaches of the standard of care had not occurred on May 10-11, 2017 then within a reasonable degree of medical probability Ms. Powell would not have died on the morning of May 11, 2017. Stated differently within a reasonable degree of medical probability Ms. Powell would not have died on the morning of May 11, 2017, had the above breaches to the standard of care not occurred.

My response to Dr. Stein's opinions:

Ms. Powell underwent a rapid response on the afternoon of May 10. Shortly thereafter, the patient was seen by both the pulmonologist and the infectious disease physicians and further orders were given, including an order for a chest CT. She was attended to appropriately and was given IV antibiotics, steroids, additional oxygen, and was seen by the nursing and respiratory staff throughout the night. As previously stated, it is unlikely that she had an acute aspiration event. The findings noted on the autopsy were likely a direct result of her initial aspiration event with a likely progression to ARDS. It is also highly likely that Ms. Powell suffered from an acute mucous plug event just prior to her death, which more frequent or a higher level of monitoring would have prevented.

I disagree with Dr. Stein that a transfer to ICU was mandatory. In certain situations, close monitoring is adequate for patients with severe hypoxia, depending on staff scope of practice and abilities. It is very unlikely that any medications administered, including furosemide and nebulizer therapy (bronchodilation) would have been of any benefit, as Ms. Powell was not fluid overloaded and was not suffering from Asthma or COPD.

Furthermore, as previously discussed, the nursing staff did discuss Ms. Powell's status with Dr. Concio, and the very low dose of Ativan was not below the standard of care to help relieve the associated anxiety as a result of Ms. Powell's respiratory issues. Although Dr. Stein suggests that a rapid response should have been called again at various times throughout the night, it is not unusual, nor is it below the standard of care, for nursing staff to continue to care for a patient if they are competent and able to manage the patient at the current level of care. The main aim of a rapid response is to intervene when nursing cannot adequately manage the patient and therefore is not always mandatory.

In response to the elevation of heart rate and respiratory rate, a small dose of Ativan many times may lead to a reduction in both and an improvement in oxygen saturation, as it would potentially help reduce the exaggerated sympathetic response and work of breathing.

Finally, the CT chest when ordered was not a stat order, further suggesting that Ms. Powell's status at the time and did not warrant emergent intervention. It is not the staff's duty nor the that of the hospitalist to oversee or change the recommendations of the specialists.

In conclusion, I disagree with the allegations of Dr. Stein. Ms. Powell had clear evidence of diffuse alveolar damage on autopsy and likely died from ARDS because of her initial massive aspiration. Any intervention, as suggested by Dr. Stein, inclusive of high flow oxygen, noninvasive ventilation, or mechanical ventilation would most likely not have changed the outcome for Ms. Powell. Moreover,

another rapid response evaluation would not have changed the ongoing management nor her overall outcome.

Michael Griffith, RN

I am of the opinion that Michael Pawlak, RN and Karen, Charge RN departed from the acceptable standards of nursing care for Rebecca Powell in the following manner:
-Failure to initiate Rapid Response when a patient's heart rate is greater than 130 beats per minute, a respiratory rate is greater than 28 breaths per minute, and when an acute change is patient status is present. It was documented on 5/11/2017 at 0408 that the patient, Rebecca Powell, required an oxygen delivery increase from 3 liters nasal cannula to a non-rebreather mask with a flow rate of 15 liters. The increase is oxygen requirements suggest an acute change in patient condition. It was also documented that on 5/11/2017 at 0447 Rebecca Powell had a heart rate of 140 beats per minute. Finally, it was documented on 5/11/2017 at 0408 that Rebecca Powell had a respiratory rate of 30 breaths per minute.
-Failure to adequately monitor patient when under suicide precautions. The patient must be placed in a space that provides continuous observation that can clearly identify and detect patient's movements and actions. If unable to clearly visualize patient, a 1:1 sitter must be placed in the room to continuously monitor the patient actions and movements.

It is my opinion that, within a reasonable medical-nursing probability, the above referenced deviations from the acceptable standard(s) of nursing care caused an increased chance of harm to Rebecca Powell

My response to Nurse Griffith's opinions:

As previously discussed, a rapid response need not be initiated, especially if one was done earlier that evening, especially if a nurse is competent and able to care for a patient (as was the case here) and management would like remain the same.

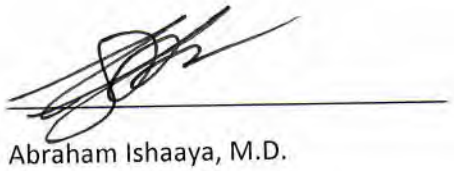
An activation of the rapid response team would have more likely than not have led to similar ongoing management that Ms. Powell was already receiving. Even a transfer to the ICU would have likely not changed Ms. Powell's management as she went into fulminant ARDS and would have, in all likelihood, had a similar outcome with any additional or more intensive oversight.

As previously discussed, although both the respiratory rate and heart rate were elevated, ongoing monitoring at the current level was appropriate under these circumstances, based on the staff's capability to intervene.

Conclusion

As I previously noted in my earlier report, which I fully incorporate as if fully outlined herein, based on my education and practice, the physicians and staff acted within the standard of care and all actions or lack of actions did not in any way contribute to her death. Allegations by plaintiffs of more frequent monitoring by Centennial Hills Hospital, staff and independent physicians is unsupported. Ms. Powell's death stemmed from an acute event which more frequent monitoring or care could not have prevented. Statements made by nursing staff at Centennial Hills Hospital to Department of Health and Human Services personnel do not accurately reflect the standard of care applicable to the care and treatment provided to Ms. Powell and those similarly diagnosed. Her death did not result from any departures from the standard of care by Centennial Hills Hospital or its personnel, nor did any such individuals breach the standard of care as it was applied to Ms. Powell's care and treatment. Her death, while tragic, resulted from the affirmative actions Ms. Powell took pertaining to her drug overdose and suicide attempt, and the conditions which developed directly therefrom. Moreover, her death was an imminent event which was not predictable. Additionally, Nurse Pawlak's opinion that Ms. Powell could have been dead for up to an hour is medically unsupported. Ms. Powell was in PEA at the time the Code Blue was called. Had she been dead for an hour, there is no way her heart could have been restarted as it had during the Code. No further interventions by Centennial Hills Hospital or its personnel could have prevented this outcome.

Dated: August 4, 2021



Abraham Ishaaya, M.D.

Exhibit C

Exhibit C

ruffalo

Adam Garth, Esq.
Lewis Brisbois
6385 South Rainbow Blvd., Suite 600
Las Vegas, Nevada 89118

Re: Estate of Rebecca Powell vs. Valley Health System, LLC (dba) Centennial Hills Hospital Medical Center

Dear Mr. Garth,

At your request I have reviewed the following documents:

1. Report of Plaintiff's Expert James F. Lineback, M.D.;
2. Report of Plaintiff's Expert Thomas A. Cumbo, M.D.;
3. Report of Plaintiff's Expert Kenny A. Stein, M.D.;
4. Report of Plaintiff's Expert Michael Griffith, R.N.

I utilized these reports and compared them to my analysis and findings contained in my initial report on this matter as whether it was appropriate to use and titrate of small doses of lorazepam (Ativan) in order to alleviate Ms. Powell's continuing anxiety, over approximately 31-33 hours prior to her death.

Upon review of the aforenoted, none of the opinions I offered in my prior report have been altered in any way and are fully incorporated herein as part of my rebuttal.

In conclusion, please note that all work is based on information provided to date, and opinions are expressed to a reasonable degree of medical certainty and probability. As additional information is provided, I may augment or amend my opinions.

Richard Ruffalo, MD, PharmD, FACCP

Dated: July 29, 2021

11 Seashell ▮ Newport Coast, CA 92657
949-675-0825 ▮ 949-675-0525 Fax

Exhibit D

Exhibit D

August 24, 2021

Mr. Adam Garth
Lewis, Brisbois LLP
6385 South Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118

Re: Estate of Powell et al. v. Valley Health System LLC, et al.

Dear Mr. Garth:

As executive vice president with JS | Held, I have been retained to evaluate economic losses claimed by plaintiffs in the above-captioned case. I have also been retained to comment upon work product and/or testimony of plaintiffs' retained damages experts. All opinions contained herein are made to a reasonable degree of economic certainty.

I have been provided with the following documents:

1. Second Supplemental Responses to Defendant Valley Health System, LLC's First Set of Interrogatories to Plaintiff Estate of Rebecca Powell Through Brian Powell as Special Administrator, dated June 17, 2021;.
2. Plaintiffs' Third Supplement to Initial Designation of Experts and Pre-Trial List of Witnesses and Documents Pursuant to NRCP 16.1(A)(3), dated June 18, 2021;
3. "Preliminary Report on Lifetime Earnings of Ms. Rebecca Powell," prepared by Terrence M. Clauretie, Ph.D, dated 6/18/2021.

I have also considered Nevada Revised Statute (NRS) 41.085.

Response to Report of Terrence M. Clauretie, Ph.D.:

The wrongful death statute in Nevada is NRS 41.085. It sets forth the recoverable damages in a wrongful death lawsuit. Representatives on behalf of the estate may only recover a) Any special damages, such as medical expenses, which the decedent incurred or sustained before the decedent's death, and funeral expenses; and b) Any penalties, including, but not limited to, exemplary or punitive damages, that the decedent would have recovered if the decedent had lived.

An heir may be awarded pecuniary damages for the person's grief or sorrow, loss of probable support, companionship, society, comfort and consortium, and damages for pain, suffering or disfigurement of the decedent.

I am unaware of any category of recoverable wrongful death damages that would be measured based solely on a projection of the lifetime earnings of a decedent. While "loss of probable support" is often related to the earnings of the decedent, Dr. Clauretie's report does not attempt to measure, not does it quantify the loss of probable support to the heirs. Dr. Clauretie's analysis does not differentiate which part of those earnings, if any, would have gone towards the probable support of the heirs, in accordance with the Nevada wrongful death statute. As such, his conclusions do not provide any guidance as to the actual economic damages, if any, suffered by the heirs of Ms. Powell. A finder of fact looking to Dr. Clauretie's report for numerical guidance in reaching a relevant determination of the probable support that would have been provided to 3 adult heirs could easily be misled by the current presentation.

Dr. Clauretie bases the lifetime earnings analysis on the assumption that Ms. Powell was earning $5,000 per month, as indicated in Brian Powell's interrogatory responses. Dr. Clauretie assumes that the decedent would have continued to earn at a level commensurate with the initial assumption of $5,000 per month until the end of a worklife expectancy for a female "with a college degree." Dr. Clauretie does not cite any review or analysis of Ms. Powells' historical income amounts from the customary sources relied upon by forensic economists, including but not limited to: income tax documents, payroll records, employment records, fringe benefit documentation, Social Security Earnings History statement, etc., nor does it appear that Dr. Clauretie was in possession of any of these materials in forming his opinions. These types of records are important for consideration, as they can assist practitioners and finders of fact in verifying the accuracy and the reasonableness of the claims being made. For example, when an earnings stream is being projected at a certain level for 16-plus years, it becomes important to look at the decedent's earnings for an extended period of time prior to death in order to assess whether the projection is reasonably supported by the data. Without additional data and documentation such as is mentioned above, one cannot verify the reliability or accuracy of Dr. Clauretie's projections.

Dr. Clauretie indicates that he based his worklife expectancy calculation on white females with a college degree, based on tables from the Richards and Donaldson 2nd edition book, "Life and Worklife Expectancies." The reference to college degree is ambiguous, as there are several different college degree categories, including Associates degree, Bachelor's degree, etc. Generally, the worklife expectancy for someone with an Associate degree is not the same as the worklife expectancy for someone the same age with a Bachelor's degree. Dr. Clauretie does not specify which worklife table and level of education he

assumed in estimating a 16.4 year worklife expectancy for Ms. Powell. As such, I am unable to opine on whether Dr. Clauretie's worklife expectancy calculation is accurate at this time. As additional information is received on this topic, I may amend or augment my comments and opinions accordingly.

Although Dr. Clauretie's report provides some interest rate data from June 4, 2021, and an Abstract from a 2014 journal article, his report does not address his rationale for selecting an "offset" method (as opposed to any other method utilized in the field of forensic economics) in this particular case. As such, I am unable to provide meaningful commentary on Dr. Clauretie's choice of the "offset" method at this time. As additional information is received on this topic, I may amend or augment my comments and opinions accordingly.

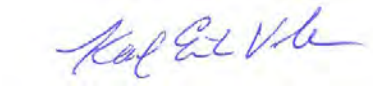
Conclusion:

In conclusion, please note that all comments in this report are based on information provided to date. As additional information is provided, I may amend or augment my comments and opinions.

Please find enclosed copies of my CV, my list of testimonies, and a company fee schedule.

If you have any questions, please do not hesitate to contact me.

Sincerely,



Karl Erik Volk, M.A.

Enclosures

EXHIBIT E

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Attorneys for the Estate

DISTRICT COURT
CLARK COUNTY, NEVADA

In the Matter of the Estate of REBECCA ANN POWELL a/k/a REBECCA A. POWELL a/k/a REBECCA POWELL, Deceased.	CASE NO.: P-17-091793-E DEPT NO.: PC-1 Probate

ORDER TO RELEASE MEDICAL RECORDS

THE COURT, having reviewed the Ex Parte Petition to Release Medical Records, and good cause appearing,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the medical records for **REBECCA ANN POWELL a/k/a REBECCA A. POWELL a/k/a REBECCA POWELL**, held with any and all medical facilities, hospitals, clinics, physicians, rehabilitation facilities, acute care facilities, nurse practitioners, and any other person or entity having medical records for the Decedent, including, but not limited to:

> **CENTENNIAL HILLS HOSPITAL and its health care providers, nurses, doctors, staff, nurse practitioners, on-site pharmacy, and/or affiliates;**

shall release copies of said medical records to **TARYN CREECY** or her attorneys.

DATED this 24 day of May, 2017.

DISTRICT COURT JUDGE

Submitted by:

CASSADY LAW OFFICES, P.C.

By: _____
Brendan M. McGraw, Esq.
Nevada Bar No. 11653

DISPOSITIONS:
☐ - Voluntary Dismissal
☐ - Transferred (before/during trial)
☐ - Involuntary (statutory) Dismissal
☐ - Judgment on Arbitration Award
☐ - Stipulated Dismissal
☐ - Stipulated Judgment
☐ - Summary Judgment
☐ - Non-Jury (bench) Trial
☐ - Jury Trial

EXHIBIT F

AFFIDAVIT OF DR. SAMI HASHIM, M.D.

STATE OF NEW YORK }

COUNTY OF WESTCHESTER }

The undersigned affiant, Dr. Sami Hashim, M.D., being first duly sworn, hereby deposes and says:

1. I have reviewed the medical records pertaining to Rebecca Powell (Date of Birth: May 30, 1975 / Date of Death: May 11, 2017).

2. This affidavit is offered based upon my personal and professional knowledge. I am over the age of eighteen and competent to testify to the matters set forth herein if called upon to do so.

3. I am a medical doctor and senior attending physician in the Division of Endocrinology and Metabolism at St. Luke's Hospital/Medical Center at Mount Sinai in New York, New York. I have been a Professor of Endocrinology, Internal Medicine, Metabolism & Nutritional Medicine at Columbia University College of Physicians & Surgeons since the early 1070's and was Chief of Metabolic Research from 1971 to 1997. I have published over 200 papers in peer-reviewed journals and am a recognized expert in the fields of internal medicine (including general medicine, which includes cardiology, neurology, pulmonology and other specialties), endocrinology, metabolism and nutrition. I have served on research review committees of the National Institute of Health. I earned my MD degree from the State University of New York, with post graduate training at Harvard University.

4. I have worked as a senior attending physician and professor at St. Luke's Hospital and Medical Center, a Mount Sinai Medical Center affiliate hospital (previously affiliated with Columbia University) for over 20 years. As a professor, I teach medical students, interns, residents all aspects of internal and general medicine, in-patient and out-patient medical care. I complete medical rounds each day seeing patients with and without medical students, interns, residents and I train Fellows in many different specialties including Emergency Medicine, Cardiology, and Pulmonary Medicine. I also attend to private patients at St. Luke's.

5. As a senior attending physician and Professor with decades of teaching and training medical students, Interns, Residents and Fellows as well as attending to my own private patients, I can attest that following Standard of Care ("SOC") protocols is crucial and essential for proper diagnosis, treatment and care management. Obviously, there are numerous SOC protocols, which begin from the time the patient is first seen and examined at a hospital/medical center, post-admission, at time of discharge and following discharge. Many of the protocols are basic, yet of critical importance to the patient's overall health welfare and ultimate recovery during the recuperation period following discharge. That is why all hospitals/medical centers respect and adhere to strict guidelines and protocols described & defined by each healthcare facility and even by federal law(s). Certainly, real-time information stated

and revealed in a patient's medical records such as all chart notes, must be carefully evaluated and considered as primary SOC as part of patient care management. Disregard of even basic protocols can lead to catastrophic events and outcomes.

6. I have reviewed the available medical records, summary reports and the HHS-Investigative Report pertaining to Rebecca Powell. Evaluation of her medical records and reconstruction of an accurate timeline was available in part (all records were requested, not all records were provided by Centennial Hills Hospital & Medical Center). In my opinion, stated to a reasonable degree of medical probability, the conduct of *Centennial Hills Hospital & Medical Center* (including its hospitalists/nurses and other healthcare providers including *Dr. Juliano Dionice, M.D., Dr. C. Concio, M.D., Dr. Vishal Shah* - presumed employees)—fell below the appropriate standards of care that were owed to Rebecca Powell. The medical records and additional medical related information I have reviewed reveal the following:

   A. On May 3, 2017 at 3:27PDT, Rebecca Powell, a 41-year old adult female, was found by EMS at home, unconscious with labored breathing and vomitus on her face. It was believed she ingested an over-amount of Benadryl, Cymbalta and Ambien. EMS intubated Ms. Powell and transported her to Centennial Hills Hospital—Emergency Department (ED). At ED, patient was evaluated and diagnosed with:
      - Respiratory Failure and low BP
      - "Overdose on unknown amount of Benadryl, Cymbalta and ETOH"
      - Review of Systems: "Within Normal Limits" (WNL)
      - Sinus Tachycardia – no ectopy
      - Lab results consistent with respiratory failure and over-dosage of suspected medications
      - Acidosis

   B. Notwithstanding clear evidence of intentional over-dosing of the substances mentioned, the Death Certificate noted the *only* cause of death was due to: "Complications of Cymbalta Intoxication." Based on medical records, the patient did not and with high probability could not have died from the cause of death stated in the Death Certificate. The patient died as a direct consequence of respiratory failure directly due to below standard of care violations as indicated by her medical records and reinforced by the Department of Health and Human Services—Division of Health Quality and Compliance Investigative Report. Furthermore:
      - After being admitted to Centennial Hills Hospital on 05/03/17, the patient's health status steadily improved over the course of almost a week.
      - Patient was extubated in the ICU and moved to a medical floor.
      - Patient's lab results improved daily.
      - Pulmonologist consultation stated that the patient felt well enough and wanted to go home. The specialist made no note to delay discharge.
      - Healthcare providers told family members from out-of-town that the patient was doing much better and "would be discharged soon." Family returned to their homes out-of-state based on the information they received.

- Metabolically, Cymbalta has a half-shelf life of approximately 12-24 hours, up to 48 hours if an over-amount is ingested. The patient didn't have a downward health status until 150 hours+ had transpired. *Therefore, the possibility that she died from Cymbalta intoxication or complication of, is not realistic.*
- There was no medical evidence of the patient ingesting Ambien, Benadryl or ETOH, nor did toxicology reports reveal any of those substances.
- On 05/04/17, the patient underwent a bronchoscopy and bronchoalveolar lavage. The report stated, *"There was no foreign material or deciduous matter evidenced."* Had the patient aspirated vomitus, there would have been some endotracheal or bronchial evidence of foreign or deciduous matter.
- From 05/07/17 – 05/11/17 – Over a period of nearly five days, medical records state the patient steadily improved.
- 05/07/17– PROGRESS NOTES state *"Patient alert and stable"* and *"Can upgrade diet to GI soft."*
- 05/08/17 – *"Patient vitals remain stable"* and *"No significant event during shifts."*
- **05/09/17** – PROGRESS NOTES (stating the patient had significantly improved and was expected to be discharged)
- *"Patient eager to go home. Denies any shortness of breath. No cough, shortness of breath or sputum production."*
- Review of Systems – Normal
- Vitals – Normal

C. Late on 05/10/17 and early hours of 05/11/17, the patient's health status changed. Initially, the changes were not even approaching critical by any stretch of consideration or concern. However, the *below standard of care related to inadequate and absent monitoring, lack of diagnostic testing and improper treatment were directly related to the patient's acutely failing health status and ultimately her pronounced death* at 6:57 AM on 05/11/17.

- On **05/10/17** at 2AM, patient started coughing and complained of SOB. Patient was receiving O2-2L/NC
- At 10:51AM – Patient's SO2 dropped to 92%
- At 3:11PM – *Patient complained of continued SOB and weakness*
- At 4:11PM – Patient complaining of increased labor for breathing, states she feels like she's *"drowning"*
- Order for breathing treatment and ***Ativan IV Push*** ordered by *Dr. Shah* & administered for anxiety with no improvement.
- Dr. Shah contacted who ordered STAT ABG and 2 view x-ray – Results showed possible infiltrates or edema.

D. On **05/11/17**, the patient's health status markedly declined.
- At 2AM – A STAT CT scan of chest was ordered.
- At 2:20AM – ***Ativan IV Push*** (.5mg) was ordered by *Dr. Concio* & administered.
- At 2:40AM – *CT Lab called to state patient was being returned to her room (701) and CT could not be completed due to patient's complaint of SOB and anxiety.*
- **(Note: At the very least, a portable x-ray should have been ordered when the patient was returned to her room. <u>It wasn't</u>.)**
- At 3:27AM – ***Ativan IV Push*** was again ordered by *Dr. Concio* & administered.

- At 3:45AM – RT-Tech (Venessa) was called to assess the patient. Indicated that the patient was not cooperative and kept removing the O2 mask. Also stated the patient needed to be monitored with a "sitter." Karen contacted House Supervisor David to explain that a sitter was needed. He suggested placing the patient in wrist restraints. When asked to closely monitor the patient, the camera monitor (John) noted that the resolution of the camera/monitor did not allow him to see the patient enough to discern when she attempted to remove the mask. He advised moving the patient to a room with better video capability. ***The patient did not receive a "sitter" nor was she moved to another room with adequate monitoring capability.***

- The patient was mis-diagnosed with 'anxiety disorder' by an unqualified healthcare provider and there was no differential diagnosis presented by any physician at any time on 05/11/17 when the patient was suffering from respiratory insufficiency.
- Based on the administration of multiple doses of ***Ativan IV Push***, the fact that the patient had been receiving daily doses of Midazolam (*another Benzodiazepine causing respiratory depression*), Acetylcysteine (*can also cause respiratory symptoms*), (at least four other drugs with side effects of SOB, labored breathing and cough) and the period of time from Ativan dosing to Code Blue was *within* less than 90 minutes. Given the medication regimen the patient was on, it's highly probable that administering the back to back doses of ***Ativan IV Push*** to this patient (already in respiratory distress), the inadequate and absent monitoring of the patient and other below standards of care as verified in the Investigative Report, were all directly related to the patient's acute respiratory failure leading to the final cardiorespiratory event and death.

7. Dr. Dionice, Dr. Concio and Dr. Shah, in my expert opinion, each one breached their duty.

A. Based on radiological reports as late as 05/10/17, stating there were no significant changes from 05/08/17, noting *"possible infiltrates or edema."* This is extremely relevant in diagnosing and treating the patient's sudden respiratory change in health status late 05/10/17 and 05/11/17.

- Since the patient was unable to undergo a CT scan due to "anxiety", ***at the very least*** a portable x-ray should have been ordered to determine if and what significant pulmonary changes were present based on the presence of acute signs & symptoms. *Each of the three physicians aforementioned were aware of the patient's acutely declining health status and were responsible for not only ordering an alternative diagnostic imaging such as a portable x-ray, but also obtaining & reporting the results to determine pulmonary involvement based on her symptoms*. Medical records do not reveal a portable x-ray ordered when the CT scan was unable to be completed, nor any results of any x-ray ordered after the attempted CT scan when the patient was returned to her room.
- Based on the patient's stable condition until late 05/10/17 and her acute decline in health status on 05/11/17, an immediate differential diagnosis should have been made, which *absolutely should have included the possibility of side effect(s) and adverse reaction(s) from medications being administered*. *Given the nature of the sudden onset of the patient's symptoms, drug side effects and interactions should have been reviewed by each of the three physicians aforementioned.* The patient had been receiving six drugs, including Ativan administered on 05/09/17 and 05/10/17, all having side effects directly

related to the symptoms and findings displayed by the patient at the time her health acutely worsened on 05/10/17 & 05/11/17.

- Without consideration of the probable drug side effects, adverse reactions and interactions, which were most probably directly related to the patient's acute symptoms, *the three physicians aforementioned, ignored even the possibility that her medications might be the cause of her symptoms & declining health status. Consequently, not one of the three physicians aforementioned even placed drug(s) side effects/adverse reactions on any differential diagnosis*.
- Instead of performing their professional duty related to prescribed and administered medications, *all three of the physicians aforementioned were aware of the decision to administer even more* ***Ativan IV-Push****, multiple times in a short period of time to treat the patient's symptom of anxiety. It was the responsibility of each of the three physicians to have been aware and knowledgeable that administering Ativan to a respiratory compromised patient has significant risks related to serious pulmonary/respiratory function*. The FDA provides warnings with the use of benzodiazepines of such risk. Interactions with other drugs (not only when used concomitantly with opiates) can compound the seriousness of the risk(s).
- *Had any of the three physicians aforementioned, reviewed the patient's drug regimen, they would have realized that several of the drugs caused, shortness of breath (SOB) and associated anxiety, cough, labored breathing, weakness and other related symptoms exhibited by the patient. Had any of the three aforementioned physicians, reviewed the side effects, Ativan (known to potentially cause and/or increase respiratory depression) would not have been administered, especially not by IV-Push (the effects are much faster and more dramatically pronounced).*

8. Department of Health and Human Services—NV Bureau of Health Quality and Compliance Investigative Report, not only reinforced my findings, but revealed many other below standard of care violations, all related directly to the wrongful death of the patient. The information below, provides examples of other below standard of care violations found in the medical records and as part of the HHS—NV Bureau's Investigation:
    - There was no specific differential diagnosis shown in the records related to her complaints and abnormal findings between 05/10/17 to 05/11/17.
    - The records stated numerous times that the patient needed to be elevated to a higher level of care and required ***close*** monitoring. ***Neither were provided.***
    - **Respiratory Therapist** – *("...the RT concluded the physician should have been notified, the RRT activated and the level of care upgraded.")* ***The physician was not notified, the RRT was not activated and the level of care was not elevated.***
    - **Registered Nurse** – *("...RN explained normal vital signs were: B/P: 100/60, HR: no more than 100 bpm, RR: 16-20 br/m and SPO2 no less than 92%. If a patient with a HR of 130 bpm and RR of 30 br/m, the physician* ***must*** *be notified immediately and the RRT activated.")* **The patient had a HR of 130, SPO2 below 92% while receiving 3+ liters of oxygen and a respiratory rate of 30 bpm.**.*")* ***The physician was not notified.***
    - **The Legal 2000 Patient Frequency Observation Record** – *("*...they could not see the incident on monitor and again advised to change the patient to room 832 (with working camera). The record revealed at 6:10 AM, Code Blue was announced. The record indicated the patient *"last appeared to be sitting in close to upright position with fingers*

possible in mouth for approximately one hour.") **IMPORTANT NOTE – The patient was not changed to a different room as earlier advised. Hence, she was not being adequately monitored, which was of critical importance.** ***The last sentence in this record reveals that for at least one hour the patient was in severe respiratory distress and during that hour, no RN or CNA checked on the patient. This contradicts other records and statements made by the RN and the CNA.***

- **Chief of Nursing Operations** – *("…*the *Chief of Nursing Operations (CNO) indicated that the patient should have been monitored closely based on the vital signs and condition. The CNO acknowledged the Rapid Response Team (RRT) should have been activated and the patient upgraded to a higher level of care.")* ***The RRT was not activated nor was the patient elevated to a higher level of care.***
- **Process Improvement Manager** – *("…*the facility *Process Improvement Manager indicated the patient was not monitored by telemetry and the cardiac monitoring documentation available for 05/11/17 was the EKG performed during the Code Blue.")* **The patient was already known to be in respiratory distress before she coded. According to this record-note, the patient was not receiving any cardiac monitoring and was only monitored during the code. (This is a shameful and gross example of below standard of care. Any patient in respiratory distress needing a re-breather mask and receiving the same medications for the present acute health status, must be on telemetry to monitor cardiac status. In this patient's case, it was critically important given the fact she had been administered multiple *IV PUSH* doses of ATIVAN, a drug known to depress the respiratory system.**
- **Respiratory Therapy Supervisor** – *("...RT Supervisor confirmed according to the vital signs documented in the record on 05/11/17 at 4:08 AM and 4:47 AM, the patient was in respiratory distress and required an upgrade of the level of care.")* **On more than one occasion during the same hour, the patient required being upgraded to a higher level of care, *but wasn't upgraded.* This note also indicates that during that hour between 4:00 AM – 5 AM, no RN or CNA checked on the patient. This contradicts other records and statements made by the RN and the CNA.**

9. In my expert opinion, stated to a reasonable degree of medical probability, the failure to properly diagnose the patient before she became acutely critical on 05/11/17, the failure of the healthcare provider staff to adequately monitor the patient (also stated in the HHS-Investigative Report), the failure to properly diagnose the patient, the failure to provide proper treatment (***lacking review of the patient's medications***) and administering the drug (*Ativan*) several times ***IV-Push*** in a respiratory compromised patient, inclusively & directly led to the patient's wrongful death. Additionally, there were many other below Standard of Care violations as revealed and reported by the Department of Health and Human Services, Nevada—Bureau of Health Care Quality and Compliance – Investigation Report (Complaint Number - NV00049271) also related directly to Rebecca's Powell's wrongful death.

I declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge and belief. I reserve the right to change my opinions pending production and review of additional medical records.

Dr. Sami Hashim, M.D.

Dated: 1/23/2019

Sworn to me before this 23rd day

of January, 2019.

Notary Public

BONNIE LEUNG
Notary Public - State of New York
NO. 01LE6264261
Qualified in New York County
My Commission Expires 06/24/2021

EXHIBIT G